Printed: 06/03/2014 FORM APPROVED OMB NO. 0938-0391

	INT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	175169			B. WING		06/03	06/03/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE			
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		TH PO BO				
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F 000	INITIAL COMMENTS			F 000				
	The following citations represent the findings of a Health Resurvey. 483 10(b)(11) NOTIFY OF CHANGES		s of a					
	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident;			F 157				
	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative		tive s an in sician dent's , a sial nent of arge					
	or interested family m change in room or roo specified in §483.15(resident rights under l	nember when there is a commate assignment as						
	the address and phon	ord and periodically upd ne number of the reside or interested family men	ent's					
	The facility reported a	not met as evidenced bacensus of 13 with 17					(VO) PATE	
LABORATOR	Y DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATI\	/E'S SIGNATURE		TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/0	3/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE		
			4TH PO BO YVILLE, KS				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 157	interview and record in ensure 1 resident (#6 member received not change in condition. Findings included: Resident (#62's) 14 MDS (Minimum Data a BIMS (Brief Interviet of 3 (a score of 0-7 in cognition), required limit with bed mobility, wall locomotion on and off assistance of 2 staff visteady when moving position, walking, turn opposite direction who off the toilet, and surfatunctional limitation in both lower extremities recorded, fell in the late admission, and no frace 6 months prior to admit admission of the following Cognitive Loss/Demedementia. Falls - Patient is at rishelp with activities of medications. The resident's 4/6/14 interventions: Skilled daily assessment in needed.	review, the facility failed and the facility failed and admission 4/23/14 set) assessment, recown for Mental Status) so dicated severely impair mited assistance of 1 pking in the room/corride assistance of 1 pking in the room/corride and the unit; required extervith transfers, balance afrom seated to standing ing around and facing alle walking, moving on a face to surface transfers a ROM (range of motions, used a walker, no fall ast 2-6 months prior to acture related to a fall inhission. The Area Assessment) agareas: The Area Assessment area and and patient's care plan, had the followent. The Large plan, had the followent. The Large plan, had the followent. The Large plan, had the followent.	d to family 's 4 rded core red erson or, nsive not g the and s, n) on ls n the	F 157			
	dementia. Falls - Patient is at ris help with activities of medications. The resident's 4/6/14 interventions: Skilled daily assessm Fall risk assessment in needed.	sk for falls due to needing daily living and patient care plan, had the followent.	ng s owing				

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	175169 F PROVIDER OR SUPPLIER STREE			B. WING	06/03/2014	
	OVIDER OR SUPPLIER VILLE REGIONAL ME	DICAL CENTER SNF		ESS, CITY, STA ITH PO BO VILLE, KS	X 850	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY F R LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 157	patient subject/treatr Intervention of 4/7/1. Restorative Evaluati Intervention of 4/10/ -Restorative Treatme Intervention of 4/22/ Intervention of 4/25/ Restorative Evaluati Intervention of 5/13/ inpatient evaluation. Intervention of 5/13/ star on door frame a resident. Intervention of 5/13/ times. Intervention of 5/13/ bedside. Keep assis cane, bedside comm Intervention of 5/13/ contraindicated. The resident's 4/23/ interventions: Inpatient evaluation. Place and keep yello Place and keep yello Bed/chair alarm on a Keep assistive device walker, cane, bedsid bed. Use gait belt unless The 4/7/14 skilled nu recorded a bed alarr Nursing notes on 5/8 the resident's roomn	4 - Rehabilitation - Inpatiment note. 4 - Occupational Therapon. 14 - Rehabilitation ent. 14 - Hot pack treatment. 14 - Physical Therapy on. 14 - Physical Therapy 14 - Place and keep yell and yellow bracelet on 14 - Bed/chair alarm on 14 - Keep assistive devices yell and yellow bracelet on 14 - Legait belt unless 14 - Use gait belt unless 14 care plan had the follow star on the door framow bracelet on resident. 15 at all times. 16 yes at bedside, such as the commode, on exit side of exit all times. 16 yes at bedside, such as the commode, on exit side contraindicated. 17 urse notes at 10:03 AM	ow at all ces at alker, owing e. e of	F 157		

PLJT11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		175169		B. WING		06/0	3/2014
	OVIDER OR SUPPLIER	DICAL CENTER SNF	1400 W	RESS, CITY, STA 4TH PO BC YVILLE, KS	X 850		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 157	B) and CNA (certified room and found the refront of the roommate head was by the room resident's feet rested. The resident reported the resident and found reported he/she tried resident did not have clinical record lacked the family/dpoa (dura receiving notification of the resident up in the charalarm, no needs voice behavior. Review of the resident documentation of the resident's discharge for 5/14/2014 at 12:2 the resident fell at hor the left hip, the staff's been able to verify the Thursday when he/sh	nurse aide) entered the esident lying on the flood's chair. The resident's nate's feet, and the towards the resident's no pain. Staff assessed no injuries. The residence of the doctor ble power of attorney) of the fall, at that time. The feed action of the fall, at that time. The residence of the doctor ble power of attorney) of the fall, at that time. The resident's activity and appointment with down. Skilled daily assessment orded the resident ories ception; gait/transferring forgets limitations; fall of motion. At 1:04 Phir, call bell within reached and with pleasant at's ECR lacked	bed. ed dent . The The or ed ecord octor t of nted ig risk M, the i, bed unit. stated tured not I last the	F 157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/0	3/2014
COFFEYVILLE REGIONAL MEDICAL CENTER SNF 14			1400 W	RESS, CITY, STA 4TH PO BO YVILLE, KS	X 850		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 157	Continued From page today. A family member report AM they were not not the resident was a part family member further to be notified in the excondition, however, duntil later, when they 5/9/14. I insisted on a getting the resident he The X-ray (completed fractured hip. On 5/20/14 at 7:22 AI stated the resident fell has a fractured hip. Vany change in condition of the content of	ported on 5/15/2014 at 8 ified of a fall on 5/8/14 tient in the hospital. The reported being the pervent of any change in id not know about the fatook the resident home a X-ray after realizing at ome, he/she could not be a X-ray after realizing at ome, he/she could not be a X-ray after realizing at ome, he/she could not be a X-ray after fealizing at ome, he/she could not be a X-ray after realizing at ome, he/she could not be a X-ray after realizing at ome, he/she could not be a X-ray after realizing at ome, he/she could not be a X-ray after realizing at one for the family on and call the doctor. AM, licensed staff L staturs, we complete an inclination of the family ever questioned me about the family practice is to notify the fit is not documented, if it is not documented,	d d d d d d d d d d d d d d d d d d d	F 157		APPROPRIATE	
	duty on 5/8/14 when the was lunch time. The with the over bed table heard a loud noise and roommate had turned the resident before stany injuries and assist text paged the doctor	M, licensed staff B (nursithe resident fell) stated resident was up in the de over his/her lap. The did the call light went off on the call light. I cheat aff got him/her up, didnated the resident to bed, and we kept checking call doctor came up and	it chair e staff . The cked 't find . I				

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	DDRESS, CITY, STATE, ZIP CODE				
	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BO				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 157	checked on the reside to call the family mem sure I tried one time, it. On 5/22/14 at 8:11 Al if staff notified him/he 5/8/14, he/she stated him/her when a reside them doing that, and the resident the next of the facility's policy for seriously ill patients, it is a policy regarding a time to facility in a patie physician.	ent after the fall. I atternber by phone. I know but not sure if I docume. M, physician D, when a r when the resident fell the staff usually text part falls. I don't remem I delete my pages. I saday on Friday, 5/9/14. PM, the facility had a fae, the facility had not lotimely notification of famr r communications regal	for ented sked on aged aber aw x ocated nilies. rding as the	F 157				
	physical restraints im discipline or convenie treat the resident's me. This Requirement is The facility reported a with 17 selected for s	BE FREE FROM INTS right to be free from an posed for purposes of ence, and not required the edical symptoms. not met as evidenced the edical symptoms. a census of 13 resident ample review. Based of the edical symptoms.	by: s, on	F 221				

NAME OF PROVIDER OR SUPPLIER COFFEVILLE REGIONAL MEDICAL CENTER SNE STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W 4TH P D B XX 580 COFFEVILLE, KS 67337 PROVIDER'S PLAN OF CORRECTION (BACH DEPRICENCY MUST SE PRECEDED BY SILL REGULATORY OR LSC IDENTIFYING INFORMATION) F 221 Continued From page 6 restraints imposed for staff convenience and not required to treat the resident for medical symptoms. Findings included: - The facility admitted resident #65 on 5/7/14, per the ECR (electronic care record), and discharged to an assisted living facility, on 5/16/14. The 5/16/14 admission MDS (minimum data set) assessment, included the resident scored 10 on the BIMS (brief interview of mental status) assessment, included massistance of 2 staff for the demandal minimal status assessment, included the resident required extensive assistance of 2 staff for the demandal minimal status assessment further identified the resident required extensive assistance of 2 staff for transfers. The assessment further identified the resident required assistance with ADLs (activities of daily living) related to decreased cognition and weakness and used the bed rails for assistance with positioning. The 5/16/14 care plan lacked instructions to staff for the use of the bed side rails and transfer	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
COFFEYVILLE REGIONAL MEDICAL CENTER SNF 1400 W 4TH PO BOX 850 COFFEYVILLE, KS 67337 COMPUTED CONTINUED STATEMENT OF DEFICIENCIES COFFEYVILLE, KS 67337 CONTINUED STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREPIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREPIX TAQ PROVIDERS PLAN OF CORRECTION COMPUTED SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 221 Continued From page 6 F 221 restraints, remained free of physical restraints imposed for staff convenience and not required to treat the resident for medical symptoms. Findings included: The facility admitted resident #65 on 5/7/14, per the ECR (electronic care record), and discharged to an assisted living facility, on 5/16/14. The 5/16/14 admission MDS (minimum data set) assessment, included the resident scored 10 on the BIMS (brief interview of mental status) assessment, included extensive assistance of 2 staff for transfers. The assessment further identified the resident required extensive assistance of 2 staff for transfers. The assessment further identified the resident used bed side rails daily as a physical restraint. The 5/19/14 CAAs (care area assessment) identified the resident needed assistance with ADLs (activities of daily living) related to decreased cognition and weakness and used the bed rails for assistance with positioning. The 5/16/14 care plan lacked instructions to staff		175169			B. WING		06/0	3/2014
COFFEYVILLE, KS 67337 CAN ID PROVIDER'S PLAN OF CORRECTION CAN CAN	NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE	•	
PREFIX TAG (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) F 221 Continued From page 6 restraints, remained free of physical restraints imposed for staff convenience and not required to treat the resident for medical symptoms. Findings included: - The facility admitted resident #65 on 5/7/14, per the ECR (electronic care record), and discharged to an assisted living facility, on 5/16/14. The 5/16/14 admission MDS (minimum data set) assessment, included the resident status) assessment, included the resident required extensive assistance of 2 staff for bed mobility and limited assistance of 2 staff for transfers. The assessment further identified the resident used bed side rails daily as a physical restraint. The 5/19/14 CAAs (care area assessment) identified the resident needed assistance with ADLs (activities of daily living) related to decreased cognition and weakness and used the bed rails for assistance with positioning. The 5/16/14 care plan lacked instructions to staff	COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF					
restraints, remained free of physical restraints imposed for staff convenience and not required to freat the resident for medical symptoms. Findings included: - The facility admitted resident #65 on 5/7/14, per the ECR (electronic care record), and discharged to an assisted living facility, on 5/16/14. The 5/16/14 admission MDS (minimum data set) assessment, included the resident scored 10 on the BIMS (brief interview of mental status) assessment, included the resident moderately impaired cognitive status. The resident required extensive assistance of 2 staff for bed mobility and limited assistance of 2 staff for transfers. The assessment further identified the resident used bed side rails daily as a physical restraint. The 5/19/14 CAAs (care area assessment) identified the resident needed assistance with ADLs (activities of daily living) related to decreased cognition and weakness and used the bed rails for assistance with positioning. The 5/16/14 care plan lacked instructions to staff	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY F	ULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	_D BE	COMPLETION
on 5/7/14 at 12:43 PM and on 5/12/14 at 8:44 PM, the interdisciplinary nursing notes, identified the use of 4 bed side rails, in the up position, on the resident's bed. On numerous occasions,	F 221	restraints, remained for restraints imposed for required to treat the resident for medical s. Findings included: - The facility admitted the ECR (electronic corecord), and discharg facility, on 5/16/14. The 5/16/14 admission assessment, included scored 10 on the BIM status) assessment, included scored 10 on the BIM status) assessment, imoderately impaired or resident required extensistance of 2 staff for transfers. The assess resident used bed sid daily as a physical resident field the resident ADLs (activities of dadecreased cognition a used the bed rails for The 5/16/14 care plar for the use of the bed assistance needs. On 5/7/14 at 12:43 PI PM, the interdisciplinatine use of 4 bed side	ree of physical restaff convenience and ymptoms. If resident #65 on 5/7/1- are ed to an assisted living on MDS (minimum datal the resident S (brief interview of mendicating cognitive status. The ensive or bed mobility and limitor sment further identified e rails straint. If are area assessment) reeded assistance with living) related to and weakness and assistance with position lacked instructions to side rails and transfer. If and on 5/12/14 at 8:4 ary nursing notes, identicalls, in the up position	4, per set) ental ited the th ning. staff	F 221			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE	•	
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BC VILLE, KS			
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F 221	Continued From page position. A fall risk assessment identified the resident 11, indicating the resident 12, indicative the resident 13, indicating the resident 14, indicating the resident 14, indicating the resident 15, indicating the resident 15, indicating the resident 15, indicating the resident 15, indicating the resident 11, indi	t, dated 5/7/14 at 12:44 scored dent as a high risk for fam, the resident sat in twith a personal safety at geriatric wheelchair. M, therapy staff H and ed the resident with the resident with the resident with the resident rested in an and with limited assist on both sides of the bollower sections of the bollower secti	PM, alls. the larm the cance on the ed, ed. g ils on bed ent mes 4	F 221		PRIATE	
	needed limited assista	d capable of getting out					

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	OVIDER OR SUPPLIER	EDICAL CENTER SNF		ESS, CITY, STA TH PO BC VILLE, KS	X 850			
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY F OR LSC IDENTIFYING INFORMA	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) OMPLETION DATE	
F 221	Continued From p	age 8		F 221				
	staff A, reported the		cility)					
	The facility policy, dated 5/25/10, for Restraint of Patients, included the resident with the right to be free from restraints, of any kind, not medically necessary or imposed for coercion, discipline, convenience, or retaliation by staff. Additionally, the restraint procedure documented it as preferable to plan staffing to accommodate one on one observation rather than a restraint. The condition of the restrained patient shall be assessed every 15 minutes and documented on an electronic restraint flow sheet. The facility failed to ensure this resident remained free of physical restraints, imposed for purposes of staff convenience, when the staff used the 4 bed side rails to keep the resident in the bed.		ion by able nt.					
	483.13(c)(1)(ii)-(iii) INVESTIGATE/RE ALLEGATIONS/IN	PORT		F 225				
	been found guilty of mistreating resident had a finding enter registry concerning of residents or mist and report any kno court of law agains indicate unfitness f	ot employ individuals who of abusing, neglecting, or hats by a court of law; or hat ed into the State nurse aig abuse, neglect, mistreat appropriation of their proposed it has of actions but an employee, which wo for service as a nurse aide to the State nurse aide recommends.	ave de ment perty; by a uld e or					

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 225 Continued From page 9 or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
COFFEYVILLE REGIONAL MEDICAL CENTER SNF I400 W 4TH PO BOX 850 COFFEYVILLE, KS 67337 X41 ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PR					B. WING		06/03	3/2014
COFFEYVILLE, KS 67337 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETIC DATE	NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 225 Continued From page 9 or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.								
or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY F	ULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES	D BE	COMPLETION
The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This Requirement is not met as evidenced by: The facility reported a census of 13 resident's with 13 selected for sample review. Based on observation, interview, and record review, the facility failed to thoroughly investigate and report to the state agency, as required for 1 resident (# 62) of 1 reviewed for accidents who experienced a hip fracture of unknown origin. Findings included: - The facility admitted resident #62 on 4/6/14, per the ECR (electronic care record).	F 225	or licensing authoritie The facility must ensuinvolving mistreatmer including injuries of un misappropriation of reimmediately to the add to other officials in act through established p State survey and cert. The facility must have violations are thorough prevent further potent investigation is in progressentative and to with State law (including certification agency) wincident, and if the alliappropriate correctives. This Requirement is The facility reported a with 13 selected for sobservation, interview facility failed to thorout to the state agency, as 62) of 1 reviewed for a hip fracture of unknown facility admitted. The facility admitted.	ure that all alleged violant, neglect, or abuse, nknown source and esident property are replanistrator of the faciliticordance with State law procedures (including to iffication agency). The evidence that all alleging the investigated, and make the gress. Stigations must be reported to the officials in according to the State survey within 5 working days on the eaction must be taken. The end of the end of the eaction must be taken. The end of the end of the end of the eaction must be taken. The end of th	oorted y and w o the ed nust orted dance and f the d	F 225			

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COFFEY	ILLE REGIONAL ME	EDICAL CENTER SNF		TH PO BC			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY F IR LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
F 225	The resident's 14 da (Minimum Data Set) BIMS (Brief Interview 3 (a score of 0-7 ind cognition), required with bed mobility, wa locomotion on and cassistance of 2 staff steady when moving position, walking, turn opposite direction woff the toilet, and surfunctional limitation both lower extremitic recorded, fell in the admission, and no find months prior to additional to the following areas: Cognitive Loss/Demidementia. Falls - Patient is at richelp with activities of medications. The resident's 4/6/12 interventions: Skilled daily assessing Fall risk assessment needed. Intervention of 4/7/1 evaluation. Intervention of 4/7/1 Restorative Evaluation of 4/7/1 Restorative Treatment of 4/10/12 - Restorative Treatment of 4/10/12 - Restorative Treatment of 4/10/13 - Restorative Tr	ay admission 4/23/14 ME assessment, recorded a w for Mental Status) scoolicated severely impaired limited assistance of 1 palking in the room/corridoff the unit; required exter with transfers, balance of from seated to standing rning around and facing in ROM (range of motion es, used a walker, no fallast 2-6 months prior to racture related to a fall information. Care Area Assessment) when the folion and assistance in the folion racture plan, had the folion and assistance in the folion and assistance in the folion repairs of the fall of the	re of d re of d rerson or, ensive not g the and s, n) on ls n the with reson or and o	F 225			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	175169			B. WING		06/0	06/03/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	ATE, ZIP CODE			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 225	Intervention of 4/25/1. Restorative Evaluation Intervention of 5/13/1. inpatient evaluation. Intervention of 5/13/1. star on door frame an resident. Intervention of 5/13/1. times. Intervention of 5/13/1. bedside. Keep assist cane, bedside common Intervention of 5/13/1. contraindicated. The resident's 4/23/1. interventions: Inpatient evaluation. Place and keep yellow Place and keep yellow Bed/chair alarm on at Keep assistive devices walker, cane, bedside bed. Use gait belt unless of Staff recorded the foll computerized clinical The 4/6/14 ADL (Activation of the 4/6/14 A	4 - Physical Therapy n. 4 - Physical Therapy 4 - Place and keep yell d yellow bracelet on 4 - Bed/chair alarm on 4 - Keep assistive devices, such as worde, on exit side of bed 4 - Use gait belt unless 4 care plan had the follow w star on the door fram w bracelet on resident. all times. as at bedside, such as example commode, on exit side ontraindicated. owing in the resident's record: wity of Daily Living) at 3:52 PM - the resider en in bed. Bed mobility p; transfers 1 person	at all ces at alker, bowing e. e of nt with nted on staff e or in	F 225				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/0	06/03/2014	
	OVIDER OR SUPPLIER	OICAL CENTER SNF		ESS, CITY, STA 4TH PO BC VILLE, KS	OX 850			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 225	head was by the room resident's feet rested. The resident reported the resident and foun reported he/she tried resident did not have. Nursing notes on 5/9/only a bed alarm in pl. Staff recorded on the of 5/9/14 at 11:13 AM tolerated and appoint at 10:30 AM. Nurses notes with a s 5/9/14 at 1:03 PM recorded to person; altered per weak; mental status score of 19; full range resident up in the charalarm, no needs voice behavior. Review of the resident documentation of the resident's discharge for the resident was not actir concerned that staff of before the resident was doctor returned the casignificant other know brought back to the streadmission and to reat this time. At 10:30	nmate's feet, and the towards the resident's in towards the resident's in no pain. Staff assessed in o injuries. The resident of get up to go outside, a chair alarm in place. If 4 at 8:36 AM, recorded ace. If 4 at 8:36 AM, recorded ace. If 4 at 8:36 AM, recorded ace. If 5 discharge instruction related the resident's activity ment with doctor on 6/2 activity act	ed dent . The ed ecord as 2/14 t of ented ng risk M, the n, bed unit. ded at ed the , the	F 225				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/0	3/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
COFFEY	ILLE REGIONAL MED	ICAL CENTER SNF		4TH PO BO YVILLE, KS			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 225	appropriately to quest assessment complete list at this time. Reside on. At 11:10 PM, stat currently resting quiet displayed no signs/sy discomfort at this time. Staff recorded in the s5/9/14 at 10:55 PM, the self, with a bed alarm present. Brought back via EMS cart at 10:40 Vital signs within normassessment complete intervention list. Staff sweat pants and shirt incontinence, and charesponded appropriat to state place or time. signs/symptoms of distince. Staff recorded on the living documentation needed. Transfer supphysical assist. Staff recorded in the state of the significant other to check on the resident to check on the resident to state place of the resident of the significant other to phone. Staff docume skilled nurse facility a moaned as if in pain. he/she felt the resident that when leaving the he/she was unable to	tions by this nurse; phy ed and noted to interver dent incontinent with briff recorded the resident tly in bed with eyes closymptoms of distress or e, bed alarm set. skilled nursing notes on the resident as oriented a present and no pain sk into skilled nursing fato PM and transferred to mal limits. Physical ed at this time and note of changed the resident is to a gown, brief wet from	ntion ief ief iesed, nto ncility bed. d to from mable id no this illy not it illed y the when it the on nt ated fact , car,	F 225			

Printed: 06/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/03/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE		
	ILLE REGIONAL MEI	DICAL CENTER SNF		4TH PO BC (VILLE, KS			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETI	ION
F 225	running board of the the resident in the car reported the transfer car took approximate member stated when took 6 people including from the car into the family member stated approximately 3:30 Pleft for work at 5 PM. arrived home after working the family member stated why staff discharged resident's condition in family member stated why staff discharged resident's condition in family member stated he/she the resident in hallway during the reunit. This nurse expl was on the unit, the reunit. This nurse expl was on the unit, the regident's activity. Staff recorded in the 5:57 AM, the resident touch at this time. Display discomfort, voiced not staff recorded on the sheet at 9:38 AM the resident denied any rigo to sleep. Staff recorded on the assessment at 9:41 American staff recorded on	car until EMS could hel r. The family member of getting the resident is ally 15 minutes. The family the resident arrived hong EMS to get the resident and they arrived home at the resident failed the emely warm. Also, this did he/she did not undersithe resident since the lad declined so much. In the physician had informad been ambulating in sident's admission on the ained that while the respective had been low. 5/10/14 nursing notes at two home and light inking water and swallow When asked if warm the they are covering stated he/she yed no signs/symptoms to other needs at this time at 5/10/14 skilled nurse fluse of a bed alarm. The needs other than wanting the sidner is the sidner than wanting they are th	n the nilly ome, it lent The ber per co tand The dident staff and at the per co fee. It low the per co fee co fee. It low the per co fee	F 225			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER			1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/03/2014
	OVIDER OR SUPPLIER			ESS, CITY, STA		
COFFEYV	ILLE REGIONAL ME	DICAL CENTER SNF		4TH PO BO /VILLE, KS		
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F 225	Continued From page	ge 15		F 225		
	at 3:01 PM, revealed person physical assi the room/hall did not a bed alarm.	ng documentation, on 5/d the resident required 2 st for transfers, walking coccur, and the resident	in used			
	Staff recorded in the OT (Occupational Therapy) restorative note of 5/12/14 at 8:43 AM, diagnosis of weakness/falls. Education needs - home exercise program, safety, activities of daily living. No pain present. Left lower extremity range of motion deficit within normal limits. Moderate assistance needed for transfer. Poor rehabilitation potential.					
	The PT (physical therapy) inpatient evaluation on 5/12/14 at 10:55 AM, recorded left and right lower extremity range of motion 50% deficit. Range of motion comments - The resident having a hard time moving lower extremity due to increase in stiffness. Unable to support self in standing. Maximal assistance with transfer support provided. Decreased weight shift left, observed gait dysfunction. Gait comments - the resident scissored. The resident is confused and unable to follow one step command due to confusion. Poor rehabilitation potential. The resident had poor static sitting and standing balance, with complaints of pain.					
	Skilled nurse flow sheet on 5/12/14 at 12:20 PM documented the resident up in the chair for lunch. (family member) at the resident's bedside who stated, "We really should get an x-ray of the left leg and foot."		unch. no			
	staff acted upon the	ent's ECR lacked evidence resident's significant other of the resident's left leg	ner's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
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		173103				06/0	3/2014	
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F 225	5 Continued From page 16 foot.			F 225				
	documented the residestanding and putting of extremities, due to confide the resident unable to unable to assist or act stand needed verbal aperforming standing of maximum assistances weight on the left low. Staff recorded in the standing of the standin	mplaints of pain preser or rate pain. Resident tively participate with sand tactile cueing in with 2 person assist, with Resident not totally per extremity. Skilled daily assessment eresident oriented to as weak; full range is Resident encouraged relax. Staff recorded ssment on 5/13/14 at 9 bited full range of motic cumented the resident g self lunch, with no stress. Inpatient physical thera 3/14 at 3:10 PM, the alty in standing and put extremities due to esent, unable to rate the table to assist or active stand, needed verbal a	nt. it to th utting nt on of ed to on 0:35 on. sat py ting e ely nd nt not nity, hile ician					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/03	3/2014
	OVIDER OR SUPPLIER	DICAL CENTER SNF		ESS, CITY, STA 4TH PO BC VILLE, KS	OX 850		
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F 225	Continued From page 17			F 225			
F 225	The 5/14/14 x-ray of t joints and anterior/pos Impression - 1. Acute with 2.5 cm (centimet abnormality. On 5/14/14 at 11:15 Athe resident transferre telemetry, with diagnormality on 5/14/2014 at 12:22 the resident fell at hor the left hip, the staff's been able to verify the Thursday when he/sh On 5/20/14 at 7:22 Al resident fell on the dafractured hip. We are change in condition a On 5/21/14 at 11:05 Atold the nurse when whe/she couldn't stand been done. They told x-ray. On 5/13/14 I could that the resident had any weight on his/her. On 5/21/14 at 11:16 Anormally physical their in the notes if the resident worked on 5/12/14, at 5/13/14. At that time,	the resident's bilateral hasterior pelvis recorded:- e left hip fracture of femer) overriding. 2. No of the properties of a left hip fracture of PM, licensed staff K some last Friday and fracticuspect. The staff had reat. The resident did fall he was here. My licensed staff I stated by shift and now has a left to call the family with a left and call the doctor. AMy therapy staff H stative stood the resident up and I asked if an x-ray of me they did not do an ould see facial expression. He/she wouldn't prefit leg. AMy licensed staff L staff rapy tells us and documents.	ed e. stated tured not last last had ions put ted nents ed on lin	F 225			
	and reported the nurs recorded the resident pain. On 5/9/14, the	•	/her o a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM		A. BUILDING		(X3) DATE SURVEY COMPLETED			
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
COFFEY	/ILLE REGIONAL ME	EDICAL CENTER SNF		4TH PO BC VILLE, KS			
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F 225	staff L looked in the could not find any decould not find not f	age 18 age 18 be ECR and verified he/she discharge note done on 5 added the resident was verified well. This licensed stacked any discharge note desident was transferred to sacked any discharge note desident was wrong desident year desident year desident on the unit of the one fall on the unit decurs, we complete and the report into QA (Qual discharge well on the unit decurs, we complete and decurs and decurs decurs and decurs a	/9/14. ery staff es for o the e with inplain inged. ssist. et. iity wout stated estand ay. I as into ident into ident I The ito put	F 225			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/0	3/2014
	OVIDER OR SUPPLIER		STREET ADDR				
				4TH PO BC VILLE, KS			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 225	staff A stated we show report on the same do physician and I were incident in the car. The of the fracture until 5/ immediately, but no oprotocol when a residuassess the resident, vital signs or any appedo according to the phyractice is to notify the not documented, it was follow-up for the residuates for an x-ray of the compact of the phyractice is to notify the not documented, it was follow-up for the residuate request for an x-ray of the compact of the compact of the compact of the phyractice is to notify the not documented it. On 5/21/14 at 3:09 Ple duty on 5/8/14 when the was lunch time. The with the over bed table heard a loud noise and roommate had turned the resident before stany injuries and assist text paged the doctor the resident. The onchecked on the resident to call the resident's sknow for sure I tried of the compact o	ald have gotten the x-ray the x-ray was done. The aware of the dischance doctor nor I were aware and the aware. Our face the falls is for staff to call the doctor, report the arent injuries, and then the hysician's orders. Our face family with each fall. It is as not done. There was lent's family member's in 5/11/14 at 5:22 PM. My licensed staff B (number esident was up in the ecover his/her lap. The fall the call light. I che aff got him/her up, didnotted the resident to bed, and we kept checking call doctor came up and the tent of the fall. I attertisignificant other by phonone time, but not sure if the fall with origin to the State agencing the st	The arge vare calls all he staff If it is so no se on it chair estaff The cked all he ck	F 225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER ILLE REGIONAL MED	DICAL CENTER SNF	1400 W	ESS, CITY, STA 4TH PO BC VILLE, KS	X 850		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 225	made by the profession the individual may be neglect and/or exploit as soon as practically. The facility failed to the sound of the sound in the so	onal who determined the a victim of abuse and/onation and should be made possible. The properties are not this resident's hip and the properties are not this resident's hip and the properties are not this resident's hip	or ade nd	F 225			
	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.			F 226			
	This Requirement is not met as evidenced by: The facility had a census of 13 residents. Based on interview and record review, the facility failed to develop written policies and procedures which prohibited mistreatment, neglect, and abuse of residents.						
	reporting of abused, relderly or other adults themselves, reviewed the requirement of whereport abuse, neglect included the procedur report suspected abuse exploitation.	who are unable to pro l on 3/10/13, only addre- nich staff were required, of exploitation. The pre- re staff needed to follow se and/or neglect and/or	tect essed to policy v to				

, ,		, ,) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		175169		B. WING		06/03/2014		
	OVIDER OR SUPPLIER	EDICAL CENTER SNF	1400 W	DDRESS, CITY, STATE, ZIP CODE W 4TH PO BOX 850 FEYVILLE, KS 67337				
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F 226	a) Screening of new c) Prevention of ald livestigating of abuse/neglect/expl e) Protection of the investigation f) Identification of provestigation. On 6/2/14 at 11:43 staff A stated the facthecks upon hiring this staff member verified to include the employees in their member verified the include all the requirements.	ew employees employees ouse/neglect/exploitation suspected oitation e resident during the possible incidents which r AM, licensed administrat acility did conduct back gr of new employees. How verified the facility's policy e back ground checks of r policy. In addition, this st e facility's policy failed to irred elements.	ive round rever, new taff	F 226				
SS=E	INDIVIDUALITY The facility must proportion of the enhances each restricted for the facility reported with 17 selected for observation, intervity facility failed to main (#65) of the 17 sand ambulation. A enhance each resident in the facility failed to main (#65) of the 17 sand ambulation.	romote care for residents environment that maintain sident's dignity and respective or her individuality. is not met as evidenced to a census of 13 resident or sample review. Based of the environment of	es or ct in cy: s, con e 1 eals ed to cility					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/0	06/03/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	ATE, ZIP CODE			
COFFEY	ILLE REGIONAL MED	DICAL CENTER SNF		TH PO BOVILLE, KS				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 241	observation on 5/14/1 would expect. Findings included: - Observation on 5/14 activity staff E, pulled wheel chair, backward day room for lunch. The dressed in a hospital blanket placed across pushed the resident us the lunch tray in front for Furthermore, during the called the resident "such is/her given name. At 3:33 PM on 5/14/14 activity staff E assiste ambulation, from the room. At that time, the was open to view, with hospital gown. On 5/20/14 at 7:25 All reported the resident gown throughout his/fit powns or pajamas the skilled nursing facility. Licensed nursing staff 2:10 PM, the patients facility) felt the SNF shis/her hospital stay, a gown throughout the facility of the source of the start of the sum of	4, as a reasonable per 4/14 at 11:50 AM, reve resident # 65 in a geria ds from his/her room to The resident remained gown, with a white bed is the resident's lap. Stap to the table and place of the resident. The meal assistance, stap to the table and place of the resident. The meal assistance, stap to the table and place of the resident with day room to the resident with day room to the resident e resident's entire back honly a brief under the M, direct care staff J always wore a hospital ner hospital stay. Ported on 5/21/14 at 12 he unit usually wore horoughout the stay in the roughout the stay in the of the SNF (skilled nur tay was a continuation and remained in a hospital stay).	aled atric the aff ed aff E	F 241				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ UND PLAN OF CORRECTION IDENTIFICATION NUMB			1 ' '	LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		175169		B. WING 06/03/20			3/2014
	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
COFFEYV	ILLE REGIONAL N	MEDICAL CENTER SNF		4TH PO BO YVILLE, KS			
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F 248 SS=D	The facility failed to appropriately dress dignity, when out of the staff failed to now the staff C used Staff C residents receiving time staff C used Staff C reported, at the staff C reported to the staff C	uded the need for families nt's own personal clothing fort. o ensure the resident sed to maintain the reside of his/her room. Furtherm naintain the resident 's digress the resident by the gires the resident by the gires the resident by the grand and the SNF. At the served lunch trays to the grand and used a thermal insuitation of the styrofoam cups to serve it is and used a thermal insuitation of the served lunch trays to the grand used a thermal insuitation of the served lunch trays to the grand used a thermal insuitation of the served lunch trays to the served lunch trays to the grand used a thermal insuitation of the served lunch trays to the served lunch trays to the served lunch trays to serve it is and used a thermal insuitation of the served lunch trays to the served lunch trays	ified 12 hat bed lated e. cups the stead a gram e with ts and being by: s, on	F 241			

			1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/0	3/2014	
	OVIDER OR SUPPLIER	DICAL CENTER SNF	1400 W	ADDRESS, CITY, STATE, ZIP CODE 0 W 4TH PO BOX 850 FFEYVILLE, KS 67337				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 248	facility failed to provide activities for the resident nursing facility), included: - The facility admitted the ECR (electronic of the resident back to he resident back to he resident back to he sasessment identified intact with a score of interview for mental sersident 's activity provery important to do to and to participate in he resident required limit mobility and transfers. The 5/11/14 CAA (call included the resident ADLs (activities of dathe resident 's bilater. The 4/24/14 care plans staff in the resident's. On 4/25/14 at 1345 (15/9/14 at 17:07 (5:07) identified the staff pronewspaper to read. On 4/25/14 at 1347 (16) identified the resident news as very importal favorite activities (not plan of care), going o	le an ongoing program ents of the SNF (skilled ding 3 (#68, #9, and #6 wed for activities. Id resident #9 on 4/24/14 are record) and dischart mome on 5/14/14. In MDS (minimum data if the resident with cogn 15 on the BIMS (brief tatus) assessment. The eference included; it was hings with groups of penis/her favorite activity. Ited assistance of 1 staff is. In earea assessment), needed assistance with ily living) due to weakned allower extremities. In, lacked instruction to the activity preferences. In:45 PM) and again on PM), activity flow sheet	4 per rged 4 per rged set) ition e as cople The ffor the ess of the tss	F 248				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/03	/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE	•	
COFFEYV	ILLE REGIONAL MED	OICAL CENTER SNF		4TH PO BO YVILLE, KS			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 248	Continued From page	e 25		F 248			
	hobbies (again not ide	entified in the plan of ca	are).				
	On 5/7/14 at 1622 (2:22 PM), activity interdepartmental notes included the resident attended a chaplain visit in the day room, and staff propelled the resident back to his/her room. The resident appeared attentive and talkative with others. Review of the Activity Calendar, dated April and May, 2014, identified the staff planned the same activity each week, including the following: MondayManicure/lotion TuesdayNewspaper WednesdayChaplain Devotion ThursdayNewspaper FridayBingo or choice SaturdayBoard games/cards, puzzles SundayTV Mass Observations on 5/14/2014 and 5/15/2014, revealed the activity director on the unit for a portion of each day, and a chaplain visited on 5/15/15.		d oom.				
	lacked identification of chaplain visited on 5/2 approximately 30 min residents attended the	and 5/22/14, observation of any staff led activity. 21/14, in the day room, utes. However, no be devotions in the day red the facility without see	A for room				
	any of the residents. On 5/22/14 at 2:10 PM, licensed nursing staff B, reported the resident's identified preferences are not noted in the care plan or anywhere the staff would be able to look and determine what the resident's wished to participate in or had interest in doing. Staff B reported the patients basically		are taff e erest				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/03	/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•	
COFFEYV	ILLE REGIONAL MED	OICAL CENTER SNF		4TH PO BO (VILLE, KS			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 248	continuation of his/he spend their days work television and do receitimes a week. Staff I program frequently la attendance. On 5/14/2014 at 11:44 they attended church participated in a group reported otherwise no activities or activity prasked if the staff provereading materials, car reported the staff faile items. The facility policy for Section 1.1 Activities, dated 3/11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/	nursing facility) stay as r hospitalization and typking with therapy, watchelve newspapers several further agreed the accked residents ' 6 AM, the resident reproduce or twice and bolunch. The resident knowledge of any plan ogram for the SNF. Wided activity items such that of the such that of t	pically ning al tivity orted nned hen n as ent	F 248			
	care. Activities should include devotions with chaplains and two group activities. The facility failed to provide an ongoing activity program to meet the interests and physical, mental and psychosocial well-being for this resident. - The facility admitted resident #63 on 5/1/14 per the ECR (electric care record) and remained in the SNF (skilled nursing facility), throughout the survey. The 5/15/14 admission MDS (minimum data set) assessment identified intact cognition with a score of 15 on the BIMS (brief interview for mental status) assessment. The resident required limited assistance of 1 staff for dressing						
			the set)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/	03/2014	
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
COFFEY	/ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BC VILLE, KS				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 248	and independent for a daily living). The resi assessment it was ve clothing to wear daily, and having family invactivities, the resident important to have nevactivity. The 5/1/14 initial care complete the activity survey, and an activit care plan lacked iden desired activities. The comprehensive activities in orientation, reading mpicture books, creativiand conversation. On 5/14/14 at 1636 (4 notes, indicated the rethis date due to increal leave his/her room. On 5/16/14 at 1438 (2 notes, indicated the aprovided a few magaziwork on this weekend indicated the resident. Review of the Activity	all other ADLs (activities dent identified in the ry important to choose, taking care of his/her solved in care. Related the reported as somewhat vapapers, books and given plan, instructed staff to flow sheet, activity interface y assessment. However, a control of any residence facility lacked a try care plan, at the time of the terms of the	self, to t roup rest er the ut d the y ation, on, ary ons ring to ary les to ans. and	F 248				

NAME OF PROVIDER OR SUPPLIER COFFEYVILLE REGIONAL MEDICAL CENTER SNF STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W 4TH PO BOX 850 COFFEYVILLE, KS 67337	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
COFFEYVILLE REGIONAL MEDICAL CENTER SNF 1400 W 4TH PO BOX 850			175169		B. WING		06/03	/2014
			DICAL CENTER SNF	1400 W	4TH PO BC	X 850		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCY PROVIDER'S PLAN OF CORRECTION (X5) COMPLETIC DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY F	ULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
F 248 ThursdayNewspaper FridayBingo or choice SaturdayBoard games/cards, puzzles SundayTV Mass Observations on 5/14/2014 and 5/15/2014, identified the activity director on the unit for a portion of each day, and a chaplain visited on the afternoon of 5/14/14. On 5/20/14, 5/21/14, and 5/22/14, observations lacked identification of any staff led activity provided. A chaplain visited on the 5/21/14 for 30 minutes; however, no residents attended the devotions. On 5/22/14 at 2:10 PM, licensed nursing staff B, reported the resident's identified preferences are not noted in the care plan or anywhere the staff would be able to look and determine what the residents wished to participate in or had interest in doing. Staff B reported the resident's basically see the SNF stay as a continuation of his/her hospitalization and typically spend their days working with therapy, watching television. The residents do receive newspapers several times a week. Staff B further agreed the activity program frequently lacked residents' attendance. On 5/14/14 at 4:15 PM, the resident tysited with a guest. On 05/14/2014 at 10:36 AM, the resident reported not feeling up to participating in outside of their room activities yet. However the resident stated, they did bring me a newspaper to read, but failed to offer any other activity type Items. On 5/20/14 at 9:53 AM, the resident trested in bed, while speaking on his/her cellular phone.		ThursdayNewspape FridayBingo or choic SaturdayBoard gam SundayTV Mass Observations on 5/14 identified the activity oportion of each day, a afternoon of 5/14/14. On 5/20/14, 5/21/14, lacked identification of provided. A chaplain minutes; however, not devotions. On 5/22/14 at 2:10 Pl reported the resident not noted in the care would be able to look residents wished to p in doing. Staff B repose the SNF stay as a hospitalization and ty working with therapy, residents do receive residents. Staff B further frequently lacked residents do receive residents do receive residents do receive residents do receive residents. Staff B further frequently lacked residents do receive residents do rec	er ce hes/cards, puzzles hes/cards, puzzles hes/cards, puzzles h/2014 and 5/15/2014, director on the unit for a and a chaplain visited of any staff led activity visited on the 5/21/14 for residents attended the presidents attended the activities or anywhere the stand determine what the prically spend their days watching television. The expiration of his/hes acontinuation of his/hes accontinuation of his/hes accontinuatio	on the ons or 30 of B, s are taff ee rest cally or s he nes a ogram with a oorted eir ated, failed	F 248			

Printed: 06/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/0:	3/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE			
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BO				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 248	Continued From page	e 29		F 248				
	reported the resident, his/her room be posted now the resident seer getting out of his/her and the staff lacked known activity interests. The facility policy for a Activities, dated 3/11/Director to have available care and to include detwo group activities. The facility failed to purpogram to meet the interest of the posted to the program to meet the interest of the posted to	M, licensed nursing state upon admission, asked for no visitors. However to be doing better a room for therapy at least viedge of the resident's Skilled Nursing Unit, 10, instructed the Activable activities for all level evotions with chaplains rovide an ongoing activitierests and physical, cial well-being for this	d that ever, and st. ities els of and					
	the ECR (electronic of the resident to home of the admission 5/19/1 assessment, identified intact with a score of interview for mental so resident identified as (activities of daily living as very important to depend and participated.) The 5/10/14 initial car resident needed an activities of the second participated.	4 MDS (minimum data d the resident 's cognit 15 on the BIMS (brief tatus) assessment. Th independent with ADL's ag) and the resident rep do things with groups of e in their favorite activitive plan, instructed staff ctivity assessment and	set) ion e s orted y. the an					
		owever, the care plan last to what activities the	acked					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l` ′	LE CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/0	3/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE			
COFFEYV	ILLE REGIONAL MED	ICAL CENTER SNF		4TH PO BC VILLE, KS				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FIL LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 248	A 5/9/14 activity asseresident liked to stay regularly, kept busy wispent most of his/her. A 5/12/14, activity flow included television, rematerial, scent sensoreality orientation, tac creative expression, sidiscussion/conversatistimulation, and family. The 5/12/14 interest sistimulation, and family. The 5/12/14 interest sistimulation, and participation of the solution of the	ssment, identified the up past 9 PM, napped with hobbies, reading, at time watching TV. w sheet, identified active eality orientation, readingry stimulation, picture betile sensory stimulation sound sensory stimulation, visual sensory y visits. survey, identified music to the resident, very ding materials, keeping things with groups of peactivities, going outside ating in religious serviced: 4:44 PM), interdisciplinate staff asked the reside the day room with some the day room with some the declined and thanked ing to pass the time over the declined and thanked ing, they brought some work on. To Calendar, dated April at the staff planned the saccluding the following: To Devotion	ities ig pook ig g g g g g g g g g g g g	F 248				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/0	3/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
COFFEY	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BO VILLE, KS				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 248	FridayBingo or choice SaturdayBoard gam SundayTV Mass Observation on 5/14/2 identified the activity of portion of each day, a afternoon of 5/14/14. On 5/20/14, 5/21/14, a lacked identification of chaplain visited on 5/However, no resident On 5/15/14 at 8:12 All regarding activities of the resident had not fractivities, and further offered the resident a magazines, to do on the care would be able to look residents wished to prin doing. Staff B repose the SNF (skilled recontinuation of his/he spend their days work television and do receitimes a week. Staff I program frequently lated The facility policy for Activities, dated 3/11/Director to have available.	ce les/cards, puzzles 2014 and 5/15/2014 director on the unit for a lind a chaplain visited of and 5/22/14, observation of any staff led activity. 14/14 for 30 minutes. Is attended the devotion of attended the devotion of the staff, identified by the staff, identified like attending much indicated the staff had any items, such as book their own. My licensed nursing states identified preferences plan or anywhere the service and determine what the articipate in or had intended the patients basical pursing facility) stay as a rhospitalization and typicing with therapy, watched the patients basical pursing facility) stay as a formal properties of the active newspapers severated further agreed the active resident attendantic attendantic properties.	n the ons A ns. sident iffied never s or ff B, s are taff e rest ally a pically ning al tivity ce.	F 248				

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

Printed: 06/03/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 175169 B. WING 06/03/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER COFFEYVILLE REGIONAL MEDICAL CENTER SNF 1400 W 4TH PO BOX 850 COFFEYVILLE, KS 67337 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 248 F 248 Continued From page 32 The facility failed to provide an ongoing activity program to meet the interests and physical, mental and psychosocial well-being for this resident. F 278 483.20(g) - (j) ASSESSMENT F 278 ACCURACY/COORDINATION/CERTIFIED SS=D The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment: or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This Requirement is not met as evidenced by: The facility reported a census of 13 residents. with 17 selected for sample review. Based on interview and record review the facility failed to

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/03	3/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE		
COFFEY	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BO VILLE, KS			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY F	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 278	STREET ADDRESS STREET		F 278				

` '		` '	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/0	3/2014	
	OVIDER OR SUPPLIER ILLE REGIONAL MED	DICAL CENTER SNF	1400 W	RESS, CITY, STA 4TH PO BO YVILLE, KS	X 850			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 278	Continued From page	e 34		F 278				
	the resident as mostly spouse assisting the of the first	M, licensed nursing sta DS assessments, state ked the MDS for a life	ff B,					
	expectancy of less than 6 months. The facility failed to ensure the resident's assessments as accurate to instruct the staff in the resident care needs for the end of life expectancy.		f in					
	483.20(d), 483.20(k)(COMPREHENSIVE C			F 279				
		e results of the assessn d revise the resident's of care.	nent					
	The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.		able 's cial					
	to be furnished to attahighest practicable physychosocial well-bei §483.25; and any serbe required under §48 due to the resident's §483.10, including the under §483.10(b)(4).	ng as required under vices that would otherw 83.25 but are not provide exercise of rights under eright to refuse treatments.	dent's vise ded - ent					
	This Requirement is	not met as evidenced b	oy:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/03/2	2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE	•	
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BO VILLE, KS			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	The facility had a cen residents reviewed. E interview, and record develop a comprehen 17 residents reviewed (#62) for constipation 9 and #63) for activitie (#39) for rehabilitation. Findings include: - The facility admitted the ECR (electronic of the resident's 14 day (Minimum Data Set), interview for mental set the resident severely. The resident required person with bed mobil assistance of 2 staff of the resident bowel. Review of the resident.	sus of 12 residents, with Based on observation, review, the facility faile naive care plan for 5 of 1d, which included resided, (#34) for fluid restrictions, (#9) for nutrition and mymobility needs. If admission 4/23/14 MD recorded a BIMS (brief tatus) score of 3, indicating impaired of cognitive states and toiletic lacked instructions related habits/needs.	d to the ents on, (# d 4, per os ating tatus. sive ng.	F 279			
	On 4/6/14, Colace, 10 (twice daily) for const On 4/23/14, Fleets en BM (bowel movement identification of a BM	t) monitoring lacked or the facility providing	tion.				
	4/24/14 until 5/1/14, for Direct care staff C rep	ns to facilitate a BM, fro or 7 days. ported on 5/21/14 at 11 aff (or nurses, if presen	:42				

Printed: 06/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/	03/2014	
	VIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
COFFEYVIL	LLE REGIONAL MED	ICAL CENTER SNF		4TH PO BO YVILLE, KS				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
t t c c c c c c c c c c c c c c c c c c	licensed nurses are coresidents are having of the CNAs (certified nurses) and if seein BM for a few days, the CNAs (tertified nurses) and if no BM for several the physician. On 5/22/14 at 5 PM, listated, the nurses or formal if no BM for several the physician. On 5/22/14 at 5:03 PM staff A stated, the unit in 3 days, assess and the compact of the resident of the tertified the resident of the tertified medications/light resident with having a physician, as planned and the physician will provide medications will provide the referred and the physician will provide the physician will	the ECR. Then, daily the hecking to ensure all coutine BM's. Sometimurse aides) also look intogrammer and a resident did not have yould tell the nurse. It is a staff B the aides check the BM ral days, then the nurse of the aides check the BM ral days, then the nurse of the aides check the BM ral days, then the nurse of the aides check the BM ral days, then the nurse of the aides check the BM ral days, then the nurse of the aides check the BM ral days, then the nurse of the aides of the days, then the nurse of the staff that the facility failed not have any BM's from that the facility failed nurse of the that residents who do ent after three consecutions to the licensed nursing be notified for orders of the given. The provided the aides of the consecutions and the consist of the disciplines. The provided the disciplines.	es to the ve a ls e l	F 279				

PLJT11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBER				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	175169			B. WING		06/03/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE		
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		TH PO BC			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPL	ETION
F 279	concern of constipation - The facility admitted per the ECR (electron diagnoses of renal institution inability of the kidney concentrate urine and likely to require dialyst and congestive heart heart output and the likely to require dialyst and congestive heart heart output and the likely to require dialyst and congestive heart heart output and the likely to require dialyst and congestive heart heart output and the likely to require dialyst and congestive heart heart output and the likely to require dialyst and congestive heart heart output and the likely assessment interview for mental significantly in moderately impaired set-up help for eating assistance of 1 staff with transfers. The aidentification of any number of the resident's 1/14/1 following intervention MDS dietary assessment Weekly weights. Maintain fluid restriction However, the resident however, the resident instructions to staff in resident's actual fluid Review of nursing do following: Skilled daily assessment	d resident #34 on 1/14/ nic care record), with sufficiency, Stage IV (tr s to excrete wastes, d conserve electrolytes sis or transplant at stage failure (a condition with body becomes congest d a low sodium diet with per day, on 1/14/14. 4 admission MDS (Mini nt recorded a BIMS (bries status) score of 12, indic cognition, independent and required limited with bed mobility, and 2 ssessment lacked nutritional approaches. 4 care plan identified th s: nent. t. ions. nt's care plan lacked special country and the second control intake. cumentation included the ment, dated 1/21/14 at 8	and e IV) n low ed th a 1 mum ef cating t with estaff he ecific the	F 279			
	AM, identified bilatera	al lower extremity edem	ıa,				

	OF DEFICIENCIES F CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175169		B. WING			3/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE	-		
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		ITH PO BO VILLE, KS				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 279	Continued From page	e 38		F 279				
	with diminished lung	sounds.						
	Skilled daily assessment, dated, 1/23/14 at 8:30 AM, identified bilateral lower extremity edema, and lung sounds coarse throughout.							
	AM, identified a pulse with crackles and cou							
	(oxygen) on and weal	K.						
	Skilled nursing flow sheet, dated 2/1/14 at 9:08 AM, identified the staff pulled the resident up and repositioned the patient, in bed, at this time. The resident is currently receiving comfort care with family at bedside and receiving O2 at 5L (liters). Staff provided oral care at this time. The resident was unable to take medications at this time. A 1/24/14 RD (registered dietician) assessment, identified the resident's fluid intake order is							
	followed except on 1/2	21. A 1 L fluid restriction only 500 ml of the resident						
	Review of I&O (intake included the following 1/15/14 - oral intake - 1/18/14 - oral intake 7 1/19/14 - oral intake 9 1/20/14 - oral intake 9 1/21/14 - oral intake 9 1/27/14 - oral intake 9 1/28/14 -	720 ml. 720 ml. 720 ml. 910 ml. 920 ml. 1960 ml. 830 ml. 640 ml.						
		n 5/21/14 at 11:42 AM, dn't eat well, was weak mes.	and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/0	3/2014	
NAME OF PRO	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE			
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BO YVILLE, KS				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FILSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 279	he/she assessed the admission. Staff N fu on a fluid restriction is allotment from dietary provided by nursing. On 5/22/14 at 1:45 PN reported the resident's failed to be noted to that staff document in computer for fluid inta B further reported the intake than ordered. Staff is made aware or restrictions by shift to Direct care staff S repPM, the direct care strestrictions in report a sheet. Staff S reported the resident's fluid intawater intake into the creported the dietary son the resident trays a all of the resident's fluid intawater intake into the creported the dietary son the resident trays all of the resident's fluid intawater intake into the creported the dietary son the resident trays all of the resident's fluid restrict. The facility's policy for patients, revised on 1 resident's plan of care identified nursing diagneeds, patient care st	22/14 at 12:09 AM, reporresident within 72 hours resident within 72 hours rether noted that any resident roted that any resident roted that any resident roted that any resident roted fluid roted and the other 1/2 are formally and the law or resident's care plant the law or received more staff B noted the direct formally and the resident's fluid shift report. Forted on 5/22/14 at 2:4 aff is made aware of fluid and from the resident's formall times and computer. Staff S further and the nursing staff provides. I & O, dated 7/30/07, assuring fluid intake and ant for all patients who are sident for all patients.	s of sident to be ff B stion and , staff e care for support other er s up ovide are ccy . Of fincare tent	F 279				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BO YVILLE, KS				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 279	Continued From page	e 40		F 279				
	The facility failed to develop a comprehensive care plan for this resident which directed staff to accurately provide the limited fluids as ordered by the resident's physician.							
	- The facility admitted resident #9 on 4/24/14 per the ECR (electronic care record) and discharged the resident back to home on 5/14/14.							
	the resident back to home on 5/14/14. A 5/11/14 admission MDS (minimum data set) assessment identified the resident with cognition intact with a score of 15 on the BIMS (brief interview for mental status) assessment. The resident's activity preference included; it was very important to do things with groups of people and to participate in his/her favorite activity. The assessment additionally identified the resident required limited assistance of 1 staff for mobility and transfers, and identified the resident independent with eating after setup help provided by staff. The 5/11/14 CAA (care area assessment), included the resident needed assistance with ADLs (activities of daily living) due to weakness of the resident's bilateral lower extremities, identified		e s very and ent ent ess of entified end end end end end end end end end e					
	a diabetic diet. The 4/24/14 care plar resident needed a die assessment, weekly vassessment. Howeve specific instructions reorders, of an 1800 AE Association), lactose	etary assessment, a die weights, and meal intak er, the care plan lacked elated to the resident's DA (American Diabetic	etician ke I diet					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	OVIDER OR SUPPLIER	DICAL CENTED ONE	STREET ADDR				
COFFETT	VILLE REGIONAL ME	EDICAL CENTER SNF		4TH PO BO VILLE, KS			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY F IR LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279	indicated in the dieti 4/24/14, as well as I in the resident's acti On 5/14/2014 at 11: they attended churc participated in a gro reported otherwise ractivities or activity pasked if the staff proreading materials, creported the staff faitiems. On 5/22/14 at 2:10 Freported the resident not noted in the care would be able to loo resident's wished to in doing. Staff B repsee the SNF (skilled continuation of his/h spend their days wo television and do retimes a week. Staf program frequently I The facility failed to instruct staff in the rand nutritional need. The facility admitted the ECR (electric care of 15 on the Emental status) assessment identifications.	ician assessment, dated acking instruction to the evity preferences. 246 AM, the resident reports of the once or twice and aup lunch. The resident no knowledge of any plan program for the SNF. Wookled activity items such ards or games, the residiled to offer any of those PM, licensed nursing stant's identified preferences a plan or anywhere the sock and determine what the participate in or had interpreted the residents basid nursing facility) stay as her hospitalization and tyorking with therapy, watch ceive newspapers sever of B further agreed the act lacked residents' attendated develop a plan of care to esident's activity preferences.	staff orted nned Then n as Jent ff B, s are staff ne erest cally a pically hing al etivity ance. onces 4 per	F 279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE	•	
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BO YVILLE, KS			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	daily living). The resi assessment it was vere clothing to wear daily and having family invactivities, the resident important to have new activity. The 5/1/14 initial care complete the activity survey, and an activity the care plan lacked it desired activities. The comprehensive activities on 5/22/14 at 2:10 Pl reported the resident not noted in the care would be able to look residents wished to print in the care would be able to look residents wished to print above the SNF stay as a hospitalization and ty working with therapy, residents do receive in week. Staff B further frequently lacked residents that the frequently lacked residents that the frequently failed to do comprehensive plant of instruct staff in a consprovision of care to the	all other ADLs (activities dent identified in the ery important to choose taking care of his/her solved in care. Related treported as somewhat waspapers, books and greeplan, instructed staff to flow sheet, activity interpy assessment. However, activity interpy assessment. However, activity lacked a try care plan, at the time of the flow sheet in a the time of the flow sheet in a continuation of his/her pically spend their days watching television. The waspapers several times a continuation of his/her pically spend their days watching television. The waspapers several times a continuation of his/her pically spend their days watching television. The waspapers several times a continuation of his/her pically spend the activity products attendance. Evelop and implement and care for the resident sistent and comprehensing resident # 39 on 2/4/1 hic care record), and	self, to t roup Dest est er, ident Sare taff e rest cally r she les a logram a to sive	F 279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER YILLE REGIONAL MED	DICAL CENTER SNF	1400 W	RESS, CITY, STA 4TH PO BO YVILLE, KS	OX 850			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 279	The resident's 2/10/14 data set) assessment scored 15/15 on the Emental status) assess assistance of 1-2 staff The assessment furth with a hip fracture. The 2/4//14 CAAS (casummary) for Rehabi with a potential to inc ADL's (activities of data encouragement to be The resident required PT/occupational therapy) However, the care plainstructions to the stamobility/care needs or required. Licensed nursing staff 1:50 PM, the current computer system do needs and needed in The facility failed to discomprehensive plant or required rehabilitation.	4 admission MDS (minit, identified the resident BIMS (brief interview for sment, needed limited If for walking and toileting are area assessment litation identified the reside except and provided except and provided except and identified the ToT (physical and prehabilitation treatment and lacked any other are lated to the resident of the amount of assistant for the amount of assistant in the facility not identify resident care plans in the facility not identify resident care provement.	ng. ng. nt sident nt. ne nt. nt's nce 4 at 7 re a 6, who truct	F 279				
	F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING			F 309				
	provide the necessary or maintain the higher mental, and psychosomerical	eceive and the facility ny care and services to a st practicable physical, ocial well-being, in comprehensive assessi	attain					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		` ,	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER			RESS, CITY, STA				
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BO YVILLE, KS				
(X4) ID PREFIX TAG			ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 309	Continued From page and plan of care.	e 44		F 309				
	This Requirement is not met as evidenced by: The facility reported a census of 13 residents, with 17 selected for sample review. Based on observation, interview, and record review the facility failed to ensure 1 resident (# 34) of the 17 reviewed, received appropriate, physician ordered fluid restrictions. Findings included: - The facility admitted resident #34 on 1/14/14, per the ECR (electronic care record), with diagnoses of renal insufficiency, Stage IV (the inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes and likely to require dialysis or transplant at stage IV) and congestive heart failure (a condition with low heart output and the body becomes congested with fluid).							
	The resident's 1/21/14 Data Set) assessmen interview for mental s moderately impaired of set-up help for eating	4 admission MDS (Mini trecorded a BIMS (brie tatus) score of 12, indiccognition, independent, and required limited with bed mobility, and 2 ssessment lacked	mum ef cating t with					
	The resident's 1/14/14 following interventions MDS dietary assessment Dietician assessment	nent.	ne					

Printed: 06/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/S AND PLAN OF CORRECTION IDENTIFICATION NUMBER					(X3) DATE SURVEY COMPLETED		
		175169		B. WING		06/03/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	ATE, ZIP CODE	•	
COFFEY	ILLE REGIONAL MED	DICAL CENTER SNF		TH PO BO			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE COMPLETION	
F 309	Weekly weights. Maintain fluid restricti Review of nursing do following: Skilled daily assessm AM, identified bilatera with diminished lung: Skilled daily assessm AM, identified bilatera and lung sounds coan Skilled daily assessm AM, identified a pulse with crackles and cou (oxygen) on and wea Skilled nursing flow s AM, identified the star repositioned the patie resident is currently refamily at bedside and Staff provided oral car was unable to take m A 1/24/14 RD (register identified the resident followed except on 1/2 with dietary providing s beverage daily.	nent, dated 1/21/14 at 8 al lower extremity edem sounds. nent, dated, 1/23/14 at 8 al lower extremity edem rese throughout. nent, dated, 1/23/14 at 1 al lower extremity edem rese throughout. nent, dated 1/30/14 at 1 ar rate of 125, lung sound ughing repeatedly, O2 lik. The rate of 125, lung sound up in the resident up ent, in bed, at this time. The reserving C2 at 5L (lite are at this time. The reserving O2 at 5L (lite are at this time. The reserving only 500 ml of the resident up only 500 ml of the resident up the first fluid intake order is 1/21. A 1 L fluid restriction only 500 ml of the resident up the first fluid intake order is 1/21. A 1 L fluid restriction only 500 ml of the resident up the first fluid intake order is 1/21. A 1 L fluid restriction only 500 ml of the resident up the first fluid intake order is 1/21. A 1 L fluid restriction only 500 ml of the resident up the first fluid intake order is 1/21. A 1 L fluid restriction only 500 ml of the resident up the first fluid intake order is 1/21. A 1 L fluid restriction only 500 ml of the resident up the first fluid intake order is 1/21. A 1 L fluid restriction only 500 ml of the resident up the first fluid intake order is 1/21. A 1 L fluid restriction only 500 ml of the resident up the first fluid intake order is 1/21. A 1 L fluid restriction only 500 ml of the resident up the first fluid intake order is 1/21. A 1 L fluid restriction only 500 ml of the resident up the first fluid intake order is 1/21. A 1 L fluid restriction only 500 ml of the resident up the fluid	:21 :a, 3:30 :a, 1:30 ds 08 0 and The vith ers). sident ent, on,	F 309			

Printed: 06/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175169		B. WING	06/03/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE	•
COFFEY	ILLE REGIONAL MEI	DICAL CENTER SNF		ITH PO BC VILLE, KS		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE COMPLETION
F 309	1/25/14 - oral intake 8 1/27/14 - oral intake 8 1/28/14 - oral intake 7 1/28/14 - oral intake 8 1/28/1	830 ml. 640 ml. 710 ml. 710 ml. n 5/21/14 at 11:42 AM, dn't eat well, was weak mes. 22/14 at 12:09 AM, reporesident within 72 hours urther noted that any resist signer 1/2 the fluid by and the other 1/2 are to the resident's care plan in the I&O record of the eake/output. At 2:04 PM are resident received more Staff B noted the direct of the resident's fluid of shift report. Dorted on 5/22/14 at 2:4 taff is made aware of fluid and from the resident's fluid of shift report. Dorted on 5/22/14 at 2:4 taff is made aware of fluid and from the resident's fluid and from the resident's fluid and the nursing staff prefluids.	orted s of sident to be If B ction and , staff e care If a care	F 309		

Printed: 06/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/03/2014
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE	•
COFFEYV	ILLE REGIONAL MEI	DICAL CENTER SNF		4TH PO BO YVILLE, KS		
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F 309	Continued From pag	ge 47		F 309		
	fluid restriction diet re ordered milliliter of flu failed to have a stand	ensure this resident, on eceived only the physici uid per day when the far dardized method for all mentation of fluid restricysician.	an cility staff			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR			F 312		
	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.		to			
	This Requirement is not met as evidenced by: The facility reported a census of 13 residents. The 17 residents selected for sample review included 3 reviewed for ADL (activity of daily living). Based on observation, interview, and record review, the facility failed to provide necessary ADL assistance, for the 3 residents reviewed, including (# 59 and #66) for nail care and (#65) for dressing.					
	Findings included:					
	Findings included:					
	- The facility admitted resident #59 on 5/13/14, per the ECR (electronic care record).		14,			

· · · · · · · · · · · · · · · · · · ·	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	175169	B. WING		06/	03/2014	
NAME OF PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STA	TE, ZIP CODE			
COFFEYVILLE REGIONAL MEDICAL CENTE		00 W 4TH PO BO OFFEYVILLE, KS				
(X4) ID SUMMARY STATEMENT OF DE PREFIX (EACH DEFICIENCY MUST BE PREI TAG REGULATORY OR LSC IDENTIFYING	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 312 Continued From page 48 required extensive assistance of 1 dressing and personal hygiene. The 5/18/14 CAAS (care area assessummary) triggered ADLs (activity due to total dependence with ADLs weakness and a history of CVA (subrain cells due to lack of oxygen caimpaired blood flow to the brain by rupture of an artery to the brain). The resident's initial 5/13/14 care puthe following interventions: Shower/bathe patient twice a week ADL Documentation on 6 A and 6 in Con 5/14/2014 at 3:45 PM, observathe resident with a black substance resident's fingernails. On 5/15/14 at 3 PM, the resident subhad a shower today, but the staff during his/her fingernails. Direct care staff J reported on 5/20 AM, the aides provide showers to rewanting them on the night shift, an are dirty, the CNA's (certified nurse clean them. However, the staff repfacility lacked any schedule for the care. Sometimes the activity staff the day shift when the activity directional care, as part of the activity processing the person however, the activity staff does the nail care. On 5/21/14 at 11:42 AM staff C further identified the aides is	essment of daily living) a related to adden death of bused by blockage or allan included and a related he/she adden the adden the residents a different the residents nail do nail care on thor completes gram. Iff C, stated er, their hair al hygiene, residents 'l, direct care	F 312				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175169		B. WING	 	06/03	/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE		
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		ITH PO BO VILLE, KS			
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F 312	Continued From page	e 49		F 312			
		and again, stated, the ail care for the patients.					
		M, licensed nursing stated at the looking at nails do					
		nsure the resident iene when staff failed to oiled nails, as needed.					
	- The facility admitted per the ECR (electron	d resident #66 on 5/13/ nic care record).	14,				
	The resident's 5 day MDS (Minimum Data Set), dated 5/20/14, was not completed in the computer.		et),				
	The 5/13/14 care plan recorded the following interventions: Shave patient three times a week & prn (as needed).		3				
	Shower/bathe patient ADL (activity of daily and 6 PM.	living) documentation 6	AM				
		nentation on 5/13/14 at al hygiene per 1 persor					
		0 AM, observation iden discoloration under the s.					
	resident in bed, now trimmed and clean. T trimmed my nails mys	The resident stated I					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06	/03/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•		
COFFEYV	'ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BO VILLE, KS				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 312	Continued From page for me or not. On 5/20/14 at 7:15 And the resident is alert an nail care provided by staff further explained bath/shower on the staff further than the sta	M, direct care staff J stand oriented, and would family or on day shift. It, residents requesting vening or night shift wo pon request, and the stand the day staff activity it care as part of the activity end care as part of the residents end of the care as needed. M, licensed nursing stand be looking at nails do nature the resident recease as needed. Conic clinical record) the care #65 on 5/7/14 and care on 5/16/14. MDS (minimum data set of the resident moderated the care as a factor of th	ated have The a uld raff stated tivity es to a 7:22 s nail ff B uring sived	F 312			DATE	
	on the BIMS (brief into	erview for mental statu g the resident moderat The assessment the resident required	s)					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/0	3/2014
	OVIDER OR SUPPLIER			RESS, CITY, STA		•	
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BO (VILLE, KS			
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F 312	Continued From page hygiene/dressing. The 5/19/14 CAA (car ADLs (activities for daresident needed assist decreased cognition abed side rails, times 4 positioning. The resident's 5/16/14 the resident needed sprn (as needed), shoult lacked instructions are resident. On 5/14/14 at 11:50 A activity staff E, pulled his/her geriatric wheeroom to the day room chair up to the dining Observation further ic dressed in a hospital place properly, exposunder the gown. On 5/14/14 at 3:33 PI therapy staff H, assist ambulation back to his the resident's hospital back, revealing the reincontinence brief and under the gown. On 5/20/14 at 7:25 AI reported the resident's gown throughout his/light.	re area assessment) for ally living) identified the stance with ADLs due to and weakness, and used, for assistance with 4 care plan, instructed shaving 3 times a week wered/bathed twice a water the resident backward elchair, from the resident. The staff then pusher room table for lunch. Identified the resident gown, without the ties it ing the resident with s/her room. Upon stand I gown gapped open in esident's bare skin, with disocks on his/her body.	staff and veek. the ed sin nt's d the in skin	F 312		TAIL	
	AM, the residents of t	he unit usually wore ho oughout the stay in the	spital				

	OF DEFICIENCIES CORRECTION	` ,	I) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/03	3/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE			
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		ITH PO BO VILLE, KS				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 312	skilled nursing facility Licensed nursing staf 2:10 PM, the patients facility) stay a continu stay, and remains in a the day. Review of the Guideli undated, included the the resident's own pe resident's comfort. The facility failed to p resident with assistant	f B reported on 5/22/14 of the SNF (skilled nur ation of his/her hospital hospital gown throughnes in skilled nursing up need for families to prorsonal clothing, for the	rsing I nout nit, ovide	F 312				
	483.25(h) FREE OF A HAZARDS/SUPERVI The facility must ensuenvironment remains as is possible; and earlier adequate supervision prevent accidents. This Requirement is The facility had a cen residents reviewed. Enterview, and record provide interventions accidents for the only	SION/DEVICES are that the resident as free of accident haz ach resident receives and assistance device not met as evidenced to sus of 13 residents, wit Based on observation, review, the facility faile as planned to prevent resident (#62) who	s to by: h 17	F 323				
	environment remaine	to ensure the residents						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SI COMPLE	
		175169		B. WING		06/	03/2014
	OVIDER OR SUPPLIER ILLE REGIONAL ME	EDICAL CENTER SNF	1400 W	ESS, CITY, STA 4TH PO BC VILLE, KS	X 850		
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F 323	the ECR (electronic of dementia (progre characterized by fai hypertension (eleva). The resident's 14 da (Minimum Data Set) BIMS (Brief Intervier 3 (a score of 0-7 incognition), required with bed mobility, who locomotion on and composition, walking, to opposite direction who off the toilet, and suffunctional limitation both lower extremiting recorded, fell in the admission, and no fell of months prior to acomposite of the toilet, and suffunctional limitation both lower extremiting recorded, fell in the admission, and no fell of months prior to acomposite of the toilet, and suffunctional limitation both lower extremiting recorded, fell in the admission, and no fell of months prior to acomposite direction and the tresident's 4/6/1 interventions: Skilled daily assess	ed resident #62 on 4/6/1 care record), with diagnossive mental disorder ling memory, confusion), tion of blood pressure). ay admission 4/23/14 ME assessment, recorded a work of Mental Status) scoolicated severely impaired limited assistance of 1 palking in the room/corridor off the unit; required exter with transfers, balance of from seated to standing ming around and facing while walking, moving on urface to surface transfers in ROM (range of motiones, used a walker, no fall last 2-6 months prior to fracture related to a fall individual in activities of daily living a sions. 4 care plan, had the follows.	oses , and OS a re of d person or, ensive not g the and s, n) on ls n the for s due and owing	F 323	DEFICIENCY)		
	Interventions of 4/7/ inpatient evaluation	/14 - Physical Therapy Rehabilitation - Inpa	atient				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		175169		B. WING		06/03/2014
NAME OF PF	ROVIDER OR SUPPLIER	•	STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE	
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F 323	patient subject/treat Restorative Evaluat Intervention of 4/10 -Restorative Treatm Intervention of 4/22 Intervention of 4/23 times Intervention of 4/25 Restorative Evaluat Interventions of 5/13 inpatient evaluation star on door frame a resident. times. (In place sin at bedside. Keep a walker, cane, bedsided, and use gait bedsided, and use gai	ment note. Occupational Thera ion. /14 - Rehabilitation nent. /14 - Hot pack treatment. /14 - Bed/chair alarm on /14 - Physical Therapy ion. //// /// /// /// /// /// /// /// ///	at all ellow at all ices e of d. nents: ths; nths;	F 323		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/03/2014	
	OVIDER OR SUPPLIER		STREET ADDR				
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BC VILLE, KS			
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F 323	Continued From page	e 55		F 323			
	the use of a bed alarr	on 5/7/14 at 8 AM recon. At 12 noon, the nursisident continued with the	ses'				
	Nursing notes on 5/8/14 at 1:34 PM documented the resident's roommate turned the call light on and stated the resident fell. Writer (licensed staff B) and CNA (certified nurse aide) entered the room and found the resident lying on the floor in front of the roommate's chair. The resident's head was by the roommate's feet, and the resident's feet rested towards the resident's bed. The resident reported no pain. Staff assessed the resident, found no injuries, and assisted the						
	resident to bed. The tried to get up to go o have a chair alarm in	resident reported he/sh utside. The resident di place as care planned.	ne id not				
	Nursing notes on 5/9/ only a bed alarm in pl	114 at 8:36 AM, recorde ace.	ed				
	Nurses notes with a skilled daily assessment of 5/9/14 at 1:03 PM recorded the resident was oriented to person; had altered perception; weak with gait/transferring; mental status - forgets limitations; fall risk score of 19; full range of motion. At 1:04 PM, the resident was up in the chair, call bell within reach, and a bed alarm in place.						
	Review of the resident documentation of the resident's discharge f		unit.				
	9:50 PM, (family men and reported the resid	14 at 11:19 PM, record nber R) called from hon dent was not acting ncerned that staff dismi	ne				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 323	family member stated responding to him/he stated they would like Staff explained they or inform the doctor of the give the doctor the fa At 9:54 PM, staff text PM, the doctor return family member know brought back to the sereadmission and to reat this time. At 10:15 member and informed doctor advised that the to the skilled nurse unstated he/she was go At 10:30 PM, the resiving EMS. Staff recorded the resident bed with his/her eyes signs/symptoms of ditime, and staff set his Staff recorded in the 5/9/14 at 10:55 PM, the self, with a bed alarm present. The resident nursing facility via EM transferred to bed. The within normal limits. Staff changed the and shirt to a gown, a brief wet. The resident presents are the resident and shirt to a gown, a brief wet. The resident and shirt to a gown, a brief wet. The resident presents are the staff changed the and shirt to a gown, a brief wet. The resident presents are the staff changed the and shirt to a gown, a brief wet. The resident presents are the staff changed the and shirt to a gown, a brief wet. The resident presents are the resident presents are the staff changed the and shirt to a gown, a brief wet. The resident presents are the resident presents are the staff changed the and shirt to a gown, a brief wet. The resident presents are the staff changed the and shirt to a gown, a brief wet. The resident presents are the staff changed the and shirt to a gown, a brief wet. The resident presents are the staff changed the s	the resident was ready. It that the resident was ready at all. The family mere to talk with the doctor. Sould text page the doctor to talk with the doctor. At 1 and the call; advised to be the resident could be killed nursing unit for einstate the previous or PM, staff called the far at the family member the resident readmitted the resident readmitted the resident as aler opriately to questions be sament completed and this time. The resident efform. At 11:10 PM, staff collections of the resident resident as aler opriately to questions be sament completed and this time. The resident efform. At 11:10 PM, staff collections of the resident as aler opriately to questions be sament completed and this time. The resident efform. At 11:10 PM, staff collections of the resident as oriented with the resident as oriented and the resident as oriented.	tor, to vould ation. 0:10 let the ders mily e coack facility to by this noted was left y in this location. In to left to be desired with the desired was left y in this left to be desired was left y in this left to left to be desired was left y in this left to le	F 323				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		175169		B. WING		06/03/201	14
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE		
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F 323	The resident displayed distress or discomford. The EMS run form of PM - Received a call scene at 10:23 PM at 10:24 PM. The resident shadischarged from the resident shadischarged from the recould not walk. The floack bedroom to find The resident slept, so voice. The resident was nursing facility, and reco. Staff recorded on the living documentation not needed and the rephysical assist. Staff recorded in the experience by the declipation of the resident on the resident on the properties of the resident would be later informed the family might (5/8/14), the resident parked the collection of the collection of the family might (5/8/14), the resident parked the collection of the collection of the family might (5/8/14), the resident parked the collection of the collection of the family might (5/8/14), the resident parked the collection of the collection of the family might (5/8/14), the resident parked the collection of	ed no signs/symptoms of at this time. 55/9/14 recorded at 11:0 at 10:20 PM, arrived or nd reached the resident dent's extremity assessions was met at the from the family membrould not have been thospital as the resident family member led EMS the resident laying in bororing, and awakened to vas alert and oriented tina direct admit to the skinhad a pain level recorded at 2:53 AM, bed alarm esident required 2 personality family member R control of the skinhad at 2:53 AM, bed alarm esident required 2 personality family member R control of the skinhad at 2:53 AM, bed alarm esident required 2 personality family member R control of the skinhad at 2:53 AM, bed alarm esident required 2 personality family member R control of the skinhad at 2:53 AM, bed alarm esident required 2 personality family member R control of the skinhad at 2:53 AM, bed alarm esident required 2 personality family member R control of the skinhad at 2:53 AM, bed alarm esident required 2 personality family member R control of the skinhad at 2:53 AM, bed alarm esident required 2 personality family member R control of the skinhad at 2:53 AM, bed alarm esident required 2 personality family member R control of the skinhad at 2:53 AM, bed alarm esident required 2 personality family member R control of the skinhad at 2:53 AM, bed alarm esident required 2 personality family member R control of the skinhad at 2:53 AM, bed alarm esident required 2 personality family member R control of the skinhad at 2:53 AM, bed alarm esident required 2 personality family member R control of the skinhad at 2:53 AM, bed alarm esident required 2 personality family member R control of the skinhad at 2:53 AM, bed alarm esident required 2 personality family member R control of the skinhad at 2:53 AM, bed alarm esident required 2 personality family famil	or the trait ment of the trait ment of the trait of trait of the trait of trait of the trait of t	F 323			

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F 323	he/she felt the resident that when leaving the he/she was unable to the resident had to re running board of the of the resident in the car reported the transfer of car took approximately member stated when took 6 people including from the car in the hof family member stated approximately 3:30 P. Staff recorded in the state of t	nt's pain caused by the hospital to get into car get the resident in the st the resident's hip on car until EMS could help. The family member of getting the resident in the resident arrived hong EMS to get the residuse and into a chair. To they arrived home at M unit. 5/10/14 nursing notes at woke to name and light displayed no scomfort, voiced no other of a bed alarm on the flow sheet at 9:38 AM. Heeds other than wanting the flow of the control of th	car, the p lift n the nilly me, it ent the at nt ar The ng to ented bon, 10/14 in used and nt.	F 323				

Printed: 06/03/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06	6/03/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BC VILLE, KS				
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F 323	sheet at 4:55 PM, no Staff recorded in the orestorative note of 5/1 of weakness/falls. No extremity range of molimits and required mole for transfer. The PT (physical ther 5/12/14 at 10:55 AM, left and right lower ex deficit. Range of mot resident had a hard tile extremity due to an in resident was unable to the transfer support providecreased weight shirt dysfunction. Gait conscissored. The residestep command due to had poor sitting and scomplaints of pain. Skilled nurse flow she documented the resident. The family me resident's bedside while get an x-ray of the left Review of the resident staff acted upon the request for an x-ray of foot.	voiced no needs. 5/12/14 skilled nurse flopain present. OT (Occupational Ther. 2/14 at 8:43 AM, diagropain present. Left low officit within norm oderate assistance needs apply inpatient evaluation recorded the resident by the tremity range of motion comments - The me moving his/her low occupance in stiffness. The support self in standing maximal assistance with the resident had fit left, observed gait naments - the resident ent was unable to follow occupance of the resident ent was unable to follow occupance of the resident ent was unable to follow of the reside	apy) nosis ver al eded on on nad n 50% er e ng. ith Vone ent PM for ould ce er's and	F 323				
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	NAME OF PR	PROVIDER OR SUPPLIER	SUPPLIER	STREET ADDRE	SS, CITY, STA	TE, ZIP CODE		
COFFEYVILLE REGIONAL MEDICAL CENTER SNF 1400 W 4TH PO BOX 850 COFFEYVILLE, KS 67337	COFFEYV	YVILLE REGIONAL MED	IONAL MEDICAL CENTER SNF					
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documented the resident had difficulty in standing and putting weight on both lower extremities, due to complaints of pain present. The resident was unable to rate his/her pain. The resident was unable to assist or actively participate with sit to stand, needed verbal and tactile cueing in performing standing with 2 person assist. with maximum assistance. The resident was not totally putting weight on the left lower extremity. The skilled nurse flow sheet, dated 5/12/14, at 8:39 PM and on 5/13/14 at 5:53 AM, documented, no pain present. The skilled daily assessment on 5/13/14 at 8:55 AM, documented the resident was oriented to person, gait/transferring as weak and had full range of motion. Staff recorded on the skilled daily assessment on 5/13/14 at 9:35 AM, the resident exhibited full range of motion. At 12:33 PM, staff documented the resident sat up in the chair feeding self lunch, with no signs/symptoms of distress. Staff recorded in the inpatient physical therapy treatment note on 5/13/14 at 3:10 PM, the resident had difficulty in standing and putting weight on both lower extremities due to complaints of pain, and the resident was unable to rate the pain. The resident was unable to assist or actively participate with sit to stand, needed verbal and tactile cueing in performing standing with 2 person assist, maximum assist. The resident was not totally putting weight on the left tower extremity, but was able to put both feet down on the floor while using the urinal. Staff recorded in the skilled nurse flow sheet on 5/13/14 at 5:32 PM, the resident was unable to rate pain and resting, but would be resident was unable to rate pain and resting in bed, without	F 323	documented the resic and putting weight on to complaints of pain unable to rate his/her unable to assist or ac stand, needed verbal performing standing waximum assistance totally putting weight. The skilled nurse flow 8:39 PM and on 5/13 documented, no pain. The skilled daily asse AM, documented the person, gait/transferri range of motion. Stat daily assessment on resident exhibited full PM, staff documented chair feeding self lunc of distress. Staff recorded in the treatment note on 5/1 resident had difficulty weight on both lower complaints of pain, and to rate the pain. The assist or actively part needed verbal and ta standing with 2 person. The resident was not left lower extremity, be down on the floor white 5/13/14 at 5:32 PM, to standing with the s	ted the resident had difficulty in stage weight on both lower extremities aints of pain present. The resident rate his/her pain. The resident wassist or actively participate with eded verbal and tactile cueing in assistance. The resident was not thing weight on the left lower extrement of the pain present. In the daily assessment on 5/13/14 at amented the resident was oriented ait/transferring as weak and had a motion. Staff recorded on the skill essment on 5/13/14 at 9:35 AM, the exhibited full range of motion. At adocumented the resident sat up in ding self lunch, with no signs/symps. In the daily assessment on 5/13/14 at 3:10 PM, the mad difficulty in standing and putting the pain. The resident was unable to actively participate with sit to stan erbal and tactile cueing in perform with 2 person assist, maximum as ent was not totally putting weight extremity, but was able to put both the floor while using the urinal.	s, due s was as sit to with t mity. , at 8:55 to ull ed e 2:33 a the otoms apy g sable o d, ing sist. on the a feet	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SUF COMPLETI	
	175169			B. WING		06/0	3/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE	•	
COFFEYVILLE REGIONAL MEDICAL CENTER SNF				4TH PO BO VILLE, KS			
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F 323	Continued From page	e 61		F 323			
	signs/symptoms of dis	stress.					
		AM, the resident's physic e hips to rule out a fract					
	The 5/14/14 x-ray report of the resident's bilateral hip joints and anterior/posterior pelvis recorded the resident had an acute left hip fracture of femur with 2.5 cm (centimeter) overriding.						
		AM, the physician order	red				
	the resident transferred to acute care with a						
	diagnosis of a left hip fracture. Review of the physician's hand written progress notes were as follows: 5/6/14 at 8:25 AM - Will discuss with (significant other) nursing home placement. 5/9/14 - Fell yesterday while trying to get up from chair. Discussed with family member. Review of the physician's progress notes lacked evidence staff informed the family member of the resident's 5/8/14 fall. 5/12/14 - Brought back to SNF (skilled nursing facility). Significant other's inability to take care of the resident at home. 5/13/14 at 2:45 PM from urologist - Having difficulty standing.		from ew of nce dent's				
	resident in the showe Observation revealed bracelet on the right v Observation revealed of the resident's door AM, observation reve in the room with a cha care staff C verified thalarm in place and de	M, observation revealed r with direct care staff (the resident wore a yewrist which read Fall Rist a yellow star on the outo indicate a fall risk. aled the resident in a cair alarm in place. Direct resident had a chair stached the alarm cord of ensure proper function	C. Illow sk. utside At 11 hair ct				

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER STREET A		STREET ADDRI	ESS, CITY, STA	TE, ZIP CODE			
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BO VILLE, KS			
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F 323	Continued From page	e 62		F 323			
	On 5/14/2014 at 12:27 PM, licensed staff K stated staff suspected the resident fell at home last Friday and fractured his/her left hip. Staff was not able to verify that. The resident fell last Thursday when he/she was here.						
	On 5/20/14 at 7:22 AM, licensed staff I stated the resident fell on the day shift on 5/8/14 and now had a fractured hip. He/she was more active during the day, and a fall risk. If the resident had previous falls, we put that in the record in the						
	assessment. The computer tallied a number for the fall risk. The resident had a yellow bracelet for fall risk and a star on the outside of the doorway, bed alarm and side rails up. I don't know about a chair alarm when he/she fell.		elet				
	On 5/21/14 at 11:05 AM, therapy staff H stated, I told the nurse when we stood the resident up that he/she could not stand and I asked if an x-ray had been done. They told me they did not do an x-ray. On 5/13/14 I could see facial expressions that the resident had pain. He/she would not put any weight on his/her left leg.		o that ly o an ions				
	any weight on his/her left leg. On 5/21/14 at 11:16 AM, licensed staff L stated normally physical therapy told them and documented in the notes if the resident had pain. I worked on 5/12/14, and another nurse worked on 5/13/14. At that time, licensed staff L looked in the computer for the nursing notes on 5/13/14, and reported the nurse on duty on 5/13/14 recorded the resident was unable to rate his/her pain. On 5/9/14, direct care staff assisted the resident to a private vehicle. Licensed staff L looked in the ECR and verified he/she could not find any discharge note done on 5/9/14. This licensed staff verified the record lacked any discharge notes for 5/14/14 when the resident		pain. ked ked 3/14, /her e L not				

Printed: 06/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER			1 1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	OVIDER OR SUPPLIER	DICAL CENTED SNE		ESS, CITY, STA			
COFFEIN	TILLE REGIONAL WEL	NOAL CENTER SNP		VILLE, KS			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETI	ON
F 323	transferred to acute of stated the physician of family member) kept wrong with the resident touch the residencomplain of pain. The changed. The residencomplain of pain. The changed. The residencomplain of pain. The changed. The residencomplain of pain. The resident assist. The resident on the unit. On 5/21/14 at 11:30 At the resident's family resident out in a wheat stand very well. He/sday. I put the resident leaned against the conseats, I went and got the resident. I went at (emergency room). Vin the car either. The got EMS staff who he the car. It took 4 EMS nurse to get the resident on the car was not working on the resident was a little his/her left leg when a car. On 5/21/14 at 2:32 Pl staff A stated staff shon the same day the physician and I were incident in the car. To of the fracture until 5/immediately, but no cowas no follow-up doc	are. This licensed staff ordered an x-ray as (the saying something was ent's left leg. When you t's leg, he/she did not e resident's mobility had not was a transfer with 1 esident had only the one AM, direct care staff C smember R and I took the elchair. He/she did not she was kind of out of it in the front seat. He/she was kind of out of it in the front seat. He/she and got the nurse from EVe couldn't get the resident had only the resident S staff, me and the ER ent in the car. The resident, but kind of moaned the day the resident fell. esitant to put weight on assisting him/her into the AM, administrative licens ould receive the x-ray resident receives the x-ray r	e did d not le fall stated le that she at le thought into le fall le that she at le that she at le that she at le that	F 323			

PLJT11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	LE CONSTRUCTION	(X3) DATE SU COMPLET	
		175169		B. WING		06/0	3/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
COFFEY	ILLE REGIONAL MED	ICAL CENTER SNF		4TH PO BO YVILLE, KS			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	On 5/21/14 at 3:09 PI duty on 5/8/14 when the with the over bed table heard a loud noise arroommate had turned the resident before stany injuries and assist text paged the doctor the resident. The onchecked on the resident. The onchecked on the resident of the resident to was dementia, a history of and not being able to he/she stated I did not on 5/8/14. The family nurse on 5/14/14 and nurse's text message had talked with the nurse of the resident's message read the far concerned. The phys responded to the text the family member the family member the resident's message read the far concerned. The phys responded to the text the family member the resident's message read the far concerned. The phys responded to the text the family member the resident's message read the far concerned. The phys responded to the text the family member the resident's message read the far concerned. The phys responded to the text the family member the resident's message read the far concerned. The phys responded to the text the family member the resident's message resident the resident's message read the far concerned. The phys responded to the text the family member the resident's message resident the resident's message resident to the resident's message resident the resident's message resident the resident's message resident the resident the resident to the resident the residen	M, licensed staff B (nursthe resident was up in the de over his/her lap. The de over his/her up, didnested the resident to bed and we kept checking call doctor came up and ent after the fall. M, physician D, stated ent the day after the fall amily member thought sponsible care of him/her dent walk that day he/sichone call on 5/9/14 around wanted to bring the decelor labs (laboratory work wanted to bring the decelor labs (laboratory work walk. He/she had a decreased mental state walk. Physician D state of the connect that with the decelor labs at the family meaurses at the hospital with labeling member called the of tated that every time the dent, he/she screamed anow if you would order is left hip. My nurse's mily member was very	it chair e staff . The cked . The cked . I find . I on d	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SUF	
	175169			- WW.0			
	173103			B. WING		06/0	3/2014
	NAME OF PROVIDER OR SUPPLIER STREET A		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BO YVILLE, KS			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	bilateral hip x-rays what later with results of a licensed staff K and a resident fractured his physician D stated he 5/9/14 incident which resident in the car on fracture probably hap fall or on the 5/9/14 coverriding of the fractidentifing the fracture have changed due to On 6/2/14 at 3:30 PM the resident arrived he PM. Four EMS staff chouse and placed the member R stated he/PM where the resident family member state I around 8:05 PM, and bed, in the same posithe resident was not able self and had no falls where the resident was not able self and had no falls where the resident of time. The facility failed to in interventions, as plan impaired, dependent sustained a hip fracture. Observation of the 15/14/14 at 9:35 AM id hot water heater for whereapy) plugged into	lich were done 10 minuleft hip fracture. I talke isked him/her how the wher hip. At that time, where found out about the took 6 people to get the the 5/9/14 discharge, pened either on the 5/8 ar incident. The 2.5 cm ure indicated a delay in. The treatment may not the delay. If family member R state ome on 5/9/14 around carried the resident in the resident in the resident in bed. This is she left the house at 4: in tremained in bed. The he/she returned home the resident remained the to get out of bed by the while at home for the bronzelement fall prevention ned, for this cognitively resident who had a fall	ed to ne e The 3/14 n not ed 3:30 he family 50 is in eft eir rief n / and	F 323			
	stated he/she was no	t sure the electrical out	iet				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	175169		B. WING		06/03/2014	
NAME OF PROVIDER OR SUPPLIER COFFEYVILLE REGIONAL MED	DICAL CENTER SNF		ESS, CITY, STA			
		COFFEY	VILLE, KS	67337		
PRÉFIX (EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICENCY)	ACTION SHOULD BE TO THE APPROPRIATE	
water contact to prevand then asked anoth 7:55 AM, staff Q verifinot a GFCI outlet and disconnect the hydror be replaced. On 5/22/14 at 9:00 Al piece of unsecured cathe day room. Obser carpet lacked any typedges to prevent trippicarpet lacked any typedges to prevent trippicarpet lacked any typedges to the floor to pat 9:03 AM, houseked carpet loose and unsecured loose and unsecured in the provision of the resident of the prevent to the floor to pat 9:03 AM, houseked carpet loose and unsecured loose and unsecured loose and unsecured loose and unsecured loose and loose and loose and loose loose and loose l	round fault circuit pplications with potential ent electrical shock) or her maintenance staff. Fied the electrical outlet of stated they would collator until the outlet of the electrical outlet of stated they would collator until the outlet of the collator until the outlet of the electrical outlet, near a was secure a loose piece of the electrical outlet, near a was secure at loose piece of the electrical outlet, near a was secure at loose piece of the electrical outlet, near a was secure at loose piece of	not At was could d a ea of ece of ne ne 22/14 ne ure en ater f	F 323			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SUF COMPLET	
	175169 B. WING 06/03/2		3/2014				
	ROVIDER OR SUPPLIER	DICAL CENTER SNF	STREET ADDR	ESS, CITY, STA	,		
			COFFEY	VILLE, KS	67337		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 325	This Requirement is The facility reported a with 17 selected for so observation, interview facility failed to adequire proper weight recording reviewed for nutrition. Findings included: The facility admitted the ECR (electronic of the ECR (electronic of the ECR) (brief introduced in the BIMS (brief introduced in the BIMS (brief introduced in the BIMS) (brief introduced in the staff on a diabeted the resident indicated the resident needed a die assessment, weekly wassessments. The cainstructions related to as noted on the dietic 4/24/14. The 4/24/14 dietician the staff to provide the ordered 1800 ADA (A Association) diet, and intolerant, with small a intolerant, with small as interesting the staff to provide the ordered 1800 ADA (A Association) diet, and intolerant, with small as intolerant, with small as intolerant into	not met as evidenced by a census of 13 residents ample review. Based of a manufacture and record review, the lately monitor and ensuing for 1 resident (#9) of a manufacture record). In MDS (minimum data at the resident scored 15 erview for mental status ag intact cognition. The dent with eating after some area assessment), it's BMI (body mass indet to overweight for his/her etic diet. In the plan, instructed staff etary assessment, a die weights, and meal intake are plan lacked specific the resident's diet ordet assessment dated assessment, documente resident with the physical control of the control of the resident with the physical control of the control	s, on e ure f 3 4 per set) 5/15 s) et-up ex) Ethe dician se e ers, ted sician	F 325			

Printed: 06/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	175169			B. WING		06/03/2014
NAME OF PROVIDER OF		DICAL CENTER SNF	1400 W	ESS, CITY, STA 4TH PO BO VILLE, KS	X 850	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMAT	I .	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETION
Neight 1. On scale. 2. On lift scale. 3. On standi 4. On standi 5. On standi The 4/swallo therap loss. A 5/11 reside to the managidentifiand id risk. On 5/2 and whis/he the unat that On 5/2 report snack:	a 4/24/14, a weighting scale. a 5/5/14, a weighting scale. a 5/6/14, a weighting scale. a 5/6/14, a weighting scale. a 5/13/14, a weighting scale. a 6/14/14 dietary assent with "some" was resident's diet, and was resident's diet, gement. The asfied the patient plentified the resident plentified the resident time. a 6/14/14 at 10:55 A 6/14/14 at 7:15 Al 6/14/14 at 7:15 A	in the ECR, included: ght of 277 pounds, by b ght of 260 pounds, by H at of 244 pounds, by ght of 263 pounds, by gessesment, identified no the resident received a without a history of weig essment, identified the weight loss, partially relifor better weight essessment additionally planned to discharge he dident as a low nutritional AM, the resident noted to bathroom, and seated heelchair for discharge for t appeared in stable hea M, direct care staff J received bedtime, diabet ther reported a lack of dent experiencing any	o a ght ated ome al	F 325		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
	175169			B. WING		06/03	3/2014
NAME OF PROVIDER OR SUPPLIER STREET A		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE			
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		TH PO BO VILLE, KS			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 325	weight loss. On 5/21/14 at 11:47 A reported a lack of awa experienced a weight Licensed nursing staff when asked if the res loss, indicated the res weight fluctuations, but staff L observing the recordings, as noted a staff should have che discrepancy in the we staff weigh the reside charge nurse about a On 5/22/14 at 12:35 F the residents ' weight admission, then at 3, risk. The staff identification of 5/22/14 at 6:30 PN reported he/she would	AM, direct care staff C, areness the resident loss. If L, on 5/22/14 at 4:10 dident experienced weight experienced somether nothing significant. Unesident's actual weight above, staff L stated, through the compact of the compact o	yht ne Jpon t ne r the e o the hts. prted ed at er the All. ff B, yould	F 325	DETICIENCE!)		
F 327 SS=D	experiencing a 33 potential pound weight loss. The facility failed to adequately monitor the weight of this resident; failed to identify the inaccurate weight recordings and investigate to determine the residents actual weights, when the staff recorded weights indicating the resident experienced a 33 pound weight loss during the 19 day stay in the facility. 483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION		e to n the t he 19	F 327			
		ide each resident with					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SUF COMPLETI		
	175169			B. WING		06/0:	3/2014
	OVIDER OR SUPPLIER ILLE REGIONAL MED	DICAL CENTER SNF		ESS, CITY, STA 4TH PO BC VILLE, KS	OX 850		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 327	and health. This Requirement is The facility reported at 17 selected for samplinterview and record rensure one resident (hydration, received at hydration status. Findings included: The facility admitted the ECR (electronic of the resident to a hospital to a hospita	not met as evidenced by a census of 13 residents e review. Based on review, the facility failed #43) of one reviewed for dequate monitoring of dequate monitoring of dequate monitoring of degree record) and dischargice service on 3/18/14. CR included congestive ion with low heart output ingested with fluid). MDS (minimum data se 12/14, identified the resident, which indicated cognition. The resident and set-up help only for wallowing concerns, record identified dehydration	by: s with d to or 4, per rged et ut and et) sident r t r ceived	F 327			
	Review of the physici included monitoring o	·	,				
	The I & O records in t	He EUR recorded:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	175169			B. WING		06/03	3/2014
	OVIDER OR SUPPLIER			ESS, CITY, STA		•	
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BC /VILLE, KS			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 327	Continued From page	e 71		F 327			
	On 3/6/14, intake of 480 ml (milliliters), with output of 900 ml, which reflected a 420 ml fluid deficit.						
	On 3/7/14, intake of 7 ml, which reflected ar	'20 ml, with output of 80 n 80 ml fluid deficit.	00				
	On 3/8/14, intake of 360 ml, with output of 650 ml, which reflected a 290 ml fluid deficit.						
	On 3/9/14, intake of 720 ml, with output of 450 ml, which reflected a fluid deficit of 270 ml.		50				
		240 ml, with output of a the numbers available					
	On 3/11/14, intake of ml, which reflected a	360 ml, with output of 8 490 ml fluid deficit.	350				
	On 3/12/14, intake of ml, which reflected a	390 ml, with output of 9	500				
	On 3/13/14, intake of ml, which reflected a	720 ml, with output of 8	350				
		nented intakes and outp ts, due to incontinent br were inconclusive.					
	•	s are offered fluids duri dent had a fluid restrict of awareness of the	•				
	reported recalling the	nd recalled the residen	t				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SI COMPLE	
		175169		B. WING		06/	03/2014
	OVIDER OR SUPPLIER	EDICAL CENTER SNF	1400 W	ESS, CITY, STA 4TH PO BC VILLE, KS	X 850		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY F OR LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 327	Continued From pa			F 327			
E 220	2:15 PM, the resider restrictions, however monitoring. Upon rin the ECR, staff B failed to adequately and expected the n & O every shift and with fluid deficits or especially the 420 r. The facility failed to assess the resident when the staff failed record fluid intake a	taff B reported on 5/22/14 ent was not compliant with er, the resident required I review of the I & O record acknowledged the facility a measure intake and out the staff would review I would contact the physic of the larger quantities, and deficits. I adequately monitor and to a dequately review are and outputs, as ordered. EGIMEN IS FREE FROM	h fluid I & O lings V put V the I cian	E 220			
	Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the	or gregimen must be free for an unnecessary drug is excessive dose (including or for excessive duration monitoring; or without ade se; or in the presence of inces which indicate the door discontinued; or any	from s any g ; or equate ose	F 329			
	resident, the facility who have not used given these drugs therapy is necessal as diagnosed and crecord; and resider drugs receive gradus behavioral interven	must ensure that resider antipsychotic drugs are runless antipsychotic drugs are runless antipsychotic drug ry to treat a specific cond documented in the clinicants who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue the	nts not lition Il				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175169		B. WING	 	06/03/201	4
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE		
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		TH PO BOVILLE, KS			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COM	(X5) IPLETION DATE
F 329	Continued From page	e 73		F 329			
	The facility reported at The 17 residents sele reviewed for unnecess observation, interview facility failed to ensure remained free of unnerincluding; (#62) for be blood sugar and blood prn (as needed) pain for follow-up on prn professional professiona	owel monitoring; (#60) for dispressure monitoring a medication follow-up; (a ain medication monitoring a medication follow-up; (a ain medication monitoring dispression), with diagnose lilitus, Type II, with long then the body cannot us insulin made or the body cannot us insulin made or the body cannot us insulin made or the body cannot us insulin, hypertension sure), and pain. mum Data Set), dated MS (brief interview for of 15/15, indicating intainsident received injection an changed the insulin	s. d 5 ed on e wed for and #67) ing. 4, per oses g se ly				
	interventions: 1. Complete medicati 2. Record of teaching 3. Teach dietary man-	J.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLET	
		175169		B. WING		06/0	3/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BO			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 329	Continued From page and 4:30 PM.	e 74		F 329			
	5/2/14, included: 1. Fasting blood sugar daily. 2. Call doctor if blood 250. 3. Tenormin, 25 mg (for hypertension. 4. Hydrocodone, 7.5 PRN (as needed) for Review of the ECR id recorded information monitoring: Elevated Blood sugar On 5/3/14 at 9:13 PM On 5/8/14 at 8:22 PM On 5/11/14 at 4:19 PN Low Blood sugars: On 5/3/14 at 6:18 AM On 5/3/14 at 11:21 AN On 5/8/14 at 6:04 AM On 5/9/14 at 7:10 AM On 5/10/14 at 11:52 AON 5/12/14 at 11:39 AON 5/12/14 at 6:35 AN On 5/12/14 at 6:32 AN On 5/13/14 at 6:	entified the following related to blood sugar s: , blood sugar level of 3, blood sugar level of 2M, blood sugar level of 8M, blood sugar level of 8M, blood sugar level of 7 h, blood sugar level of 7M, blood sugar level of 8M, blood sugar level of 7M, blood sugar level of 8M, blood sugar level of 8M, blood sugar level of 9M, blood sugar level of	r over daily, aily, 30. 64. 253. 5. 74. 0. 6. 80. f 85. 63. f 75. 70. ion of for neters				
	On 5/2/14 at 4 PM - 1						

175169 B. WING		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SUR COMPLETE	
			175169		B. WING		06/03	3/2014
	NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE		
COFFEYVILLE REGIONAL MEDICAL CENTER SNF 1400 W 4TH PO BOX 850 COFFEYVILLE, KS 67337	COFFEY	/ILLE REGIONAL MED	DICAL CENTER SNF					
PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (FACH CORRECTIVE ACTION SHOULD BE COMPLETED FOR THE PROPERTY OF THE PR	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY F	ULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE
F 329 On 5/2/14 at 8.44 PM - 10/2/56, sitting. On 5/3/14 at 6.44 PM - 10/2/56, sitting. On 5/3/14 at 6.45 AM - 99/49, supine. On 5/5/14 at 6.40 AM - 110/59, supine. On 5/5/14 at 6.40 AM - 110/59, supine. On 5/5/14 at 6.40 AM - 110/59, supine. On 5/6/14 at 4.74 PM - Supine 162/81; sitting 15/0/94, standing 159/99. On 5/8/14 at 6.40 AM - 110/54 sitting. On 5/9/14 at 5.57 AM - 113/56 supine. On 5/10/14 at 5.51 AM - 93/65 supine. On 5/11/14 at 6.31 AM - 126/57 supine. On 5/12/14 at 6.31 AM - 126/57 supine. On 5/12/14 at 6.58 AM - 98/65 sitting. On 5/12/14 at 6.58 AM - 98/65 sitting. On 5/13/14 at 5.58 AM - 98/65 sitting. On 5/13/14 at 5.58 AM - 98/65 sitting. On 5/13/14 at 6.58 AM - 98/65 sitting. An undated posted sign on the door to the staff breakroom and the staff bathroom instructed staff of the need to inform the physician of systolic BP readings of less than 100 or over 140 and diastolic BP readings less than 60 or over 85. The sign instructed staff BP's recorded outside of the range, must be reported to the nurse. The signage further stated to wait 5 minutes and recheck with a manual BP culf and the nurse will make a judgment of what to do if the next vitals are abnormal. Documentation in the clinical record, reviewed from 5/2-22/14, lacked identification of the physician being notified of these abnormal BP readings. Review of the ECR for medication administration, from 5/2-22/14, lacked identification concerns regarding PRN and the facility failure to follow-up with assessments for Hydrocodone 7.5/325 mg, three times daily, PRN for pain as follows: Administered on 5/8/14 at 6:07 AM, by prior shift with pain rated at 8 for left foot pain; documented	F 329	On 5/2/14 at 8:44 PM On 5/3/14 at 6:45 AM On 5/4/14 at 5:11 AM On 5/5/14 at 6:40 AM On 5/6/14 at 4:47 PM 150/94; standing 159. On 5/8/14 at 6:40 AM On 5/9/14 at 5:57 AM On 5/10/14 at 5:57 AM On 5/10/14 at 5:51 AI On 5/11/14 at 8:30 AI On 5/12/14 at 6:31 AI On 5/13/14 at 5:58 AI On 5/14/14 at 5:45 AI On 5/15/15 at 6 AM An undated posted si breakroom and the st of the need to inform readings of less than diastolic BP readings The sign instructed st the range, must be re signage further states recheck with a manua make a judgment of v are abnormal. Documentation in the from 5/2-22/14, lacke physician being notific readings. Review of the ECR fo from 5/2-22/14, identi regarding PRN and th with assessments for three times daily, PRI Administered on 5/8/7	I - 102/56, sitting. I - 99/49, supine. I - 91/52, supine. I - 110/59, supine. I - 110/59, supine. I - 110/54 sitting. I - 113/56 supine. M - 93/66 supine. M - 126/57 supine. M - 126/57 supine. M - 123/58 supine. M - 123/58 supine. 121/59 sitting. M - 123/58 supine. 121/59 sitting. I - 113/56 supine. I - 113/56 supine. I - 113/56 supine. I - 126/57 sitting. I - 126/57 supine. I - 126/57 sup	taff d staff c BP 5. de of he e will tals ed BP attion, erns ev-up mg, shift	F 329			

Printed: 06/03/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			(X3) DATE SURVEY COMPLETED		
		175169		B. WING		06/03	3/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE	'	
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		TH PO BOVILLE, KS			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	Continued From page	e 76		F 329			
	not reassessed at 7:0 administered.	7 AM, due to prior shift	t				
	On 5/9/14 at 5:45 AM, with pain rated at 7 in the left foot with reassessment on 5/9/14 at 6:45 AM, not done for undetermined reason.						
	in the left foot, reasse	6:47 PM, with pain rated essment on 5/13/14 at 7 done administered b	7:47				
	The staff failed to real pain medication effect occasions.	ssess the resident for F tiveness on these 3	PRN				
	monitored for signs of as sweating, frequent their level of consciou	M, direct care staff J own to have diabetes a f hyper/hypoglycemia s urination or a change isness. Staff reported t they noted any of thes	uch in they				
	reported working on to completed blood sugar Staff I further stated to resident are establish documented in the EC wants to be notified.	M, licensed nursing star he night shift, and they ar monitoring as ordere he parameters for each ed by the physician and CR for when the physic Also, there is always an hysician available, 24 ho	d. n d ian n ER				
	stated staff should ha page for each of the h	AM, licensed nursing stance sent the doctor a text in the doctor and the sent the doctor and the text part of the text part is a sent the text part is	xt				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/03/2014	
	OVIDER OR SUPPLIER	EDICAL CENTER SNF	1400 W	ESS, CITY, STA 4TH PO BO VILLE, KS	X 850		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY F OR LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC	ON.
F 329	on 5/20/14 at 2:30 residents with BP's reported to the nurs and assess the resi will do a manual BP nurse. Staff T furth staff document the staff document BP's is at the systolic BP's is at the	PM, direct care staff T state over 140 or below 60 are see. Then, the nurse will godent or the direct care staff tear explained the direct care staff tear explained the direct care vital signs in the computer PM, licensed nursing stare to notify the physician above 140 or less than 10 are above 85 or below 60 resident is on BP medical curses the vitals and give in paper. The nurse looks is on a BP medication and it is not been about of exercised and the same system of sugars. Nurses are to be exercised and the reviewed and the respective to staff A reviewed and the respective to staff A reviewed and the respective to notify the PM, administrative nurses do not been able to verify a regarding the out of range PM, pharmacy staff M, staff are required to do a sesment, for effectiveness	e go aff go are er. If L, he if go; or o. titons. the go at the go aff	F 329			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLET	
		175169		B. WING		06/0	3/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BO YVILLE, KS			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 329	Continued From page	e 78		F 329			
	after administering pri	n pain medications.					
		Vital Signs, Blood Pres ed staff to report abnor					
	7/1/09 instructed staff assessed and docume each pain manageme	pain management, date f the resident would be entation would occur, a ent intervention, once a apsed for the treatment	ıfter				
	resident and notify the ordered, for blood sugmonitoring. Additional monitor the resident for pain medication admiresident remained free	ppropriately monitor the eresident's physician, agar and blood pressure ally, the facility failed to or the effectiveness of nistration, to ensure the e of unnecessary ived effective pain control	PRN				
	- The facility admitted the ECR (electronic ca	d resident #62 on 4/6/1- are record).	4, per				
	(Minimum Data Set), interview for mental so the resident severely The resident required person with bed mobi	radmission 4/23/14 MD recorded a BIMS (brief tatus) score of 3, indica impaired of cognitive so limited assistance of 1 lity and required extens with transfers and toileti	ating tatus.				
	The 4/6/14 care plan, to the resident bowel	lacked instructions rela habits/needs.	ated				
	Review of the residen included the following bowel function.	nt's physician orders medications related to					

Printed: 06/03/2014 FORM APPROVED OMB NO. 0938-0391

i i i	PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	175169		B. WING		06/0	3/2014
NAME OF PROVIDER OR SUPPLIER COFFEYVILLE REGIONAL MEDICA	L CENTER SNF		RESS, CITY, STA			
			VILLE, KS			
PRÉFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FI IDENTIFYING INFORMAT	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329 Continued From page 79			F 329			
On 4/6/14, Colace, 100 m (twice daily) for constipation 4/23/14, Fleets enemal BM (bowel movement) moved identification of a BM or the additional interventions to 4/24/14 until 5/1/14, for 7. Direct care staff C reported AM, the direct care staff (document BM's into the Elicensed nurses are check residents are having routing the CNAs (certified nurse computer and if seeing a BM for a few days, they where the stated, the nurses or the stated, the nurses or the stated, the physician. On 5/22/14 at 5:03 PM, and staff A stated, the unit's B in 3 days, assess and not On 5/22/14 at 5:30 PM, licen stated the resident did not 4/24/14 until 5/1/14, and the provide medications/intervesident with having a BM physician, as planned. The facility, 12/8/11, Bowe policy, instructed staff that have a bowel movement and ays, will be referred to the	ng (milligrams), BID on. a once for constipate onitoring lacked the facility providing of facilitate a BM, frow days. The don 5/21/14 at 11: or nurses, if present of the facility the facility the facility the nurse. Then, daily the king to ensure all the nurse all one below the facility the nurse. The don facility the facility failed the facility failed the facility failed the nurse of the facility failed the facility f	any m 42 t) e es to the ve a Is BMs f B to m d to ne y the oring not tive				

Printed: 06/03/2014 FORM APPROVED OMB NO. 0938-0391

	ND PLAN OF
175169 B. WING 06/03/2014	
NAME OF PROVIDER OR SUPPLIER COFFEYVILLE REGIONAL MEDICAL CENTER SNF 1400 W 4TH PO BOX 850 COFFEYVILLE, KS 67337	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX
F 329 PRN medications will be given. The facility failed to ensure the staff regularly assessed the resident bowel activity and failed to notify the physician, as needed to ensure no unnecessary medications for the resident. - The facility admitted resident #9 on 4/24/14 per the ECR (electronic care record) with diagnosis including; cerebrovascular accident (Cerebrovascular accident (Cerebrovascular accident (Cerebrovascular accident (Cerebrovascular accident of the strain by blockage or rupture of an artery to the brain by blockage or rupture of an artery to the brain), and hypertension (elevated blood flow to the brain by blockage or rupture of an artery to the brain), and hypertension (elevated blood pressure). Physician's orders revealed the following medications with black box warnings: 1.) Warfarin, 2 mg (milligrams), daily for preventative, ordered on 5/13/14. According to www.fda.gov http://www.fda.gov , Warfarin had a black box warning of bleeding risk. Warfarin can cause major or fatal bleeding, Perform regular monitoring of labs in all treated patients. 2.) Metoprolol Succinate, 25 mg (milligrams), daily, for hypertension, ordered on 4/26/14. According to www.fda.gov http://www.fda.gov , Metoprolol And a black box warning of ischemic heart disease (reduced blood supply to the heart). The 4/24/14 care plan, lacked instruction in care needs including the monitoring of the resident for adverse consequences associated with the administration of these 2 medications with black	

AND PLAN OF CORRECTION IDENTIF		A. BUILDING		(X3) DATE SURVEY COMPLETED
	175169	B. WING		06/03/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
COFFEYVILLE REGIONAL MEDICAL CE		4TH PO BO YVILLE, KS		
(X4) ID SUMMARY STATEMENT O PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 329 Continued From page 81 box warnings. Licensed nursing staff B, on 5/2 reported the pharmacy is support appropriate black box warning (medication administration recomedications that require black I staff reported the current compont allow the addition of black is the care plan. The facility failed to identify and resident for the adverse consect associated with the administrat medications with black box war resident. - The facility admitted resident the ECR (electronic care record Review of the physician orders following medication with black 1.) Metoprolol Tartrate, 25 mg (daily, ordered on 5/21/14, howe medication had been ordered of twice a day. According to www.fda.gov https://www.fda.gov <a h<="" td=""><th>psed to post the con the MAR and) for the pox warnings. The cuter system did pox warnings into I monitor the quences ion of these nings for this #63 on 5/1/14 per d). included the box warning: milligrams), twice ever, the in 5/1/14 at 50 mg ps://www.fda.gov>, raining of ischemic cupply to the heart). struction in care of the resident for atted with the in with a black box</th><td>F 329</td><td></td><td></td>	psed to post the con the MAR and) for the pox warnings. The cuter system did pox warnings into I monitor the quences ion of these nings for this #63 on 5/1/14 per d). included the box warning: milligrams), twice ever, the in 5/1/14 at 50 mg ps://www.fda.gov>, raining of ischemic cupply to the heart). struction in care of the resident for atted with the in with a black box	F 329		

	OF DEFICIENCIES F CORRECTION					(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/03/	/2014
NAME OF PE	OVIDER OR SUPPLIER		STREET ADDRI	ESS, CITY, STA	ATE, ZIP CODE	•	
COFFEY	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BO VILLE, KS			
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F 329	reported the pharmace appropriate black box (medication administres medications requiring staff reported the current allow the addition the care plan. The facility failed to its resident for the advers associated with the amedication with a blate. The facility admitted the ECR (electronic concluding pain. Physician's orders remedications ordered. 1.) Oxycodone/Apap (milligrams), every 4 pain, ordered on 5/12. Review of the administhe resident's stay at through 5/16/14, incluprovided to the resident and the staff failed to effectiveness of the president's pain. 2.) Ibuprofen, 800 mg pain, ordered on 5/9/Review of the administered from 5/9/Review of the medication administered from 5/9/Review of the administered from 5/9/Review	cy is supposed to post to warning on the MAR ration record) for the globack box warnings. The rent computer system of a of black box warnings dentify and monitor the rese consequences dministration of this ck box warning. It resident #67 on 5/9/14 care record) with diagnor wealed the following for pain control, included (acetaminophen), 5/328 hours, prn (as needed) 2/14. It is tration of the medication the facility, from 5/1/14 uded the medication ent on 5/13/14 at 5:57 A reassess for the form administration for the facility, three times daily, prn 14. It is tration of the medication for the facility of the medication for the facility of the f	The lid into 4, per ses d: 5 mg for on for MM, e	F 329			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/0	3/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	ATE, ZIP CODE	•	
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BC VILLE, KS			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	reassess the resident medication administrate effectiveness of the main. The 5/9/14 care plan regarding the administrative and the need for following medication of Ibuprofetracking method for the pain effectiveness. A that continuity of care medication administed documentation as to a medication to ensure guidelines are met. Administrative nursing 5/21/14 at 3:11 PM, a follow-up for effective Consulting staff M, re PM reported the residual reassessment, when medication, no matter was administered. Standard was available in the conduction in the method the reflective consulting failed to e appropriate follow-up medication for effective reflective.	I's pain following the partition to determine the medication related to the medication related to the medication of pain medication of pain medication and Tylenol lacked and Tylenol lacked and Tylenol lacked and follow-up assessment and Tylenol lacked and follow-up assessment and the regulated that any pain ared required follow-up the effectiveness of the the resident's pain control pain medications required follow-up the effectiveness of the medication ported on 5/22/14 at 1: dent needed a pain administering a promote that the protection of the medication and protection of the medication and points are the resident received on the resident received on the pain and the pain medication approach the medication and the protection of the medication and the protection of the pain and the protection of the protect	aff ions ff L pain a nt on ported trol uired . 20 on ture taff	F 329			
F 334 SS=C	IMMUNIZATIONS	stay in the SNF. A AND PNEUMOCOCO elop policies and proceo		F 334			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		175169		B. WING		06/	/03/2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
COFFEYV	ILLE REGIONAL N	MEDICAL CENTER SNF		4TH PO BO YVILLE, KS			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY F OR LSC IDENTIFYING INFORMA	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 334	each resident, or trepresentative receivements and potentimmunization; (ii) Each resident is immunization Octoannually, unless the contraindicated or immunized during (iii) The resident or representative has immunization; and (iv) The resident's documentation that following: (A) That the resident or representative was the benefits and point immunization; and (B) That the resident influenza immunization contraindications of that ensure that— (i) Before offering immunization, each legal representative the benefits and point immunization; (ii) Each resident is immunization; (iii) Each resident is immunization, unleadically contrainal ready been immunication of the resident of the	the influenza immunization the resident's legal eives education regarding that side effects of the soffered an influenza other 1 through March 31 the immunization is medical the resident has already this time period; or the resident's legal at the opportunity to refuse medical record includes at indicates, at a minimum dent or resident's legal as provided education regal otential side effects of influent either received the ation or did not receive the ation due to medical or refusal. The pneumococcal the pneumococcal the resident, or the resident regal otential side effects of the soffered a pneumococcal ess the immunization is dicated or the resident has unized; or the resident's legal at the opportunity to refuse the opportunity to refuse the opportunity to refuse the soffered and the resident has unized; or the resident's legal at the opportunity to refuse	the illy been the dures dures sarding	F 334			

			A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	EDICAL CENTED ONE				•	
TILLE REGIONAL WI	EDICAL CENTER SNF					
(EACH DEFICIE	NCY MUST BE PRECEDED BY F	ULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE
Continued From page 85 (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.		F 334				
The facility reported The 17 residents seincluded 5 reviewed interview and record ensure the resident offer of vaccination, vaccines, and docu influenza and pneur for (#60, #67, #39, Findings included: On 5/20/14 at 7:4 resident's immunization following concerns:	d a census of 13 resident elected for sample review of for immunizations. Based review, the facility failed is of the facility received a education related to the mentation of the 5 reside mococcal immunization set 161 and #65) reviewed.	s. ed on d to an ent's status wing e				
	Continued From particular (EACH DEFICIE REGULATORY) Continued From particular (IV) The resident's representative was the benefits and popenumococcal immediate pneumococcal immediate	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FREGULATORY OR LSC IDENTIFYING INFORMAT) Continued From page 85 (iv) The resident's medical record includes documentation that indicated, at a minimum, following: (A) That the resident or resident's legal representative was provided education regathe benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization due to medicontraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given a years following the first pneumococcal immunization. This Requirement is not met as evidenced in the resident or the resident's legal represent refuses the second immunization. This Requirement is not met as evidenced in the resident or the resident's legal represent refuses the second immunization. This Requirement is not met as evidenced offer of vaccination, education related to the vaccines, and documentation of the 5 reside influenza and pneumococcal immunizations for (#60, #67, #39, #61 and #65) reviewed. Findings included: On 5/20/14 at 7:45 AM, review of the follor resident's immunization records identified the following concerns:	ACOVIDER OR SUPPLIER VILLE REGIONAL MEDICAL CENTER SNF SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 85 (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This Requirement is not met as evidenced by: The facility reported a census of 13 residents. The 17 residents selected for sample review, included 5 reviewed for immunizations. Based on interview and record review, the facility failed to ensure the residents of the facility received an offer of vaccination, education related to the vaccines, and documentation of the 5 resident's influenza and pneumococcal immunization status for (#60, #67, #39, #61 and #65) reviewed. Findings included: - On 5/20/14 at 7:45 AM, review of the following resident's immunization records identified the	A BUILDING TOTALE REGIONAL MEDICAL CENTER SNF IDENTIFICATION NUMBER: 175169 STREET ADDRESS, CITY, STA 1400 W 4TH PO BC COFFETVILLE, KS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 85 (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This Requirement is not met as evidenced by: The facility reported a census of 13 residents. The 17 residents selected for sample review, included 5 reviewed for immunizations. Based on interview and record review, the facility failed to ensure the residents of the facility received an offer of vaccination, education related to the vaccines, and documentation of the 5 resident's influenza and pneumococcal immunization status for (#60, #67, #39, #61 and #65) reviewed. Findings included: - On 5/20/14 at 7:45 AM, review of the following resident's immunization records identified the following concerns:	TOORRECTION Total Several Sev	This resident or resident's legal representative was provided education regarding the benefits and potential or did not receive the pneumococcal immunization or did not receive the pneumococcal immunization and pseumococcal immunization. This Requirement is not met as evidenced by: The facility reported a census of 13 residents. This Requirement is not met as evidenced by: The facility reported a census of 13 residents. This Requirement is not met as evidenced by: The facility reported a census of 13 residents. This Requirement is not met as evidenced by: The facility reported a census of 13 residents. This Requirement is not met as evidenced by: The facility reported a census of 13 residents. The 17 residents selected for sample review, included 5 reviewed for immunizations. Based on interview and record review, the facility failed to ensure the residents of the facility received an offer of vaccination, ductation refleated to the vaccines, and documentation of the 5 residents influence and precursions documentation. This Requirement is not met as evidenced by: The facility reported a census of 13 residents. The 17 residents selected for sample review, included 5 reviewed for immunizations. Based on interview and record review, the facility failed to ensure the residents of the facility received an offer of vaccination, education refleated to the vaccines, and documentation of the 5 resident's influenze and pneumococcal immunization status for (#60, #67, #39, #61 and #65) reviewed. Findings included: - On 5/20/14 at 7:45 AM, review of the following resident's immunization records identified the following concerns:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB			A. BUILDING		(X3) DATE SURVEY COMPLETED		
		175169		B. WING		06/	03/2014
	OVIDER OR SUPPLIER	EDICAL CENTER SNF	1400 W	ESS, CITY, STA 4TH PO BC VILLE, KS	X 850	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY F IR LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 334	adult admission ass resident refused the indicated a prior vac vaccination. However in the resident's ECI evidence of providin material regarding vaccination ass resident received the pneumococcal vaccination ass resident received the pneumococcal vaccination ass resident received the pneumococcal vaccination ass identified to identify the ensure timeliness of the vaccination assidentified the resider influenza and pneumococcal vaccinations. 4. Resident #61's vaccinations to evaccinations. 4. Resident #61's vaccination assidentified the resider and pneumococcal vaccination assidentified the resider and pneu	essment, identified the influenza vaccination are conation for pneumococciver, the facility failed to identify the facility failed to identify the resident education vaccinations. accination records, in the essment, identified the einfluenza and cinations. However, the faction of the vaccinations of the vaccinations of the vaccinations. accination records, in the essment section of the Entreported a prior history mococcal vaccination. It is a failed to identify the date ensure timeliness of the essment section of the Entreportedly refused influence in the essment section of the Entreportedly refused influence in the essment section of the Entreportedly refused influence in the essment section of the Entreportedly refused influence in the essment section of the Entreportedly refused influence in the essment section assessment dutharms assessment dutharm	cal dentify dentify l) the al e facility s to e ECR y of des of e ECR, uenza the ons, ent, for	F 334			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/0	3/2014	
	OVIDER OR SUPPLIER VILLE REGIONAL MED	DICAL CENTER SNF	1400 W	ESS, CITY, STA 4TH PO BO VILLE, KS	X 850			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 371 SS=F	5/20/14 at 7:45 AM, nare interviewed regaracute hospital stay ar facility) only transfer tacute stay. The staff functional vaccination residents and their faregarding the risks ar programs. The facility failed to efacility received educavaccination information pneumococcal vaccinations to ensuratimely vaccinations, at 483.35(i) FOOD PROSTORE/PREPARE/STORE/PREPARE/STORE/PREPARE/STORE/PREPARE/STORE/STORE/PREPARE/STORE/STORE/PREPARE/STO	strative nursing staff A, eported the patients us ding vaccinations durin not the SNF (skilled nurs hat information from the acknowledged the lacks program to ensure the milies receive information densure the residents of the vaccin number of the total program to ensure the residents of the vaccin number of the total information regard to find the the resident received is required. ICURE, ERVE - SANITARY I sources approved or rry by Federal, State or estribute and serve food	ually g the sing e c of a e on nation the arding the local	F 371				
	serve foods in a sanit residents of the facilit Findings included:	ary manner, for the	-					

Printed: 06/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/0:	3/2014
	OVIDER OR SUPPLIER	DICAL CENTER SNE		ESS, CITY, STA	,		
0011211	TEEE REGIONAL MED	NOAL GENTER GRI		VILLE, KS			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371	Continued From page 88			F 371			
	The initial tour on 5/14/14 at 8:30 AM, in the kitchen identified the following concerns: 1. The hand sanitizer dispenser at the entrance						
		to operate when activa					
	 A refrigerator, near the baking preparation area, contained a stainless steel pan with a thick green liquid spillage in the bottom. Inside of this pan and in direct contact with the liquid, observation revealed 2 opened packages of unlabeled and undated tortillas. A half of an onion, sealed in an unlabeled and undated plastic bag, revealed the outer layers a brown and grayish discoloration to the outer skins. 						
	4. A container of chedays old in this refrige	ese sauce, dated 5/7/1/ erator.	4, 7				
	· · · · · · · · · · · · · · · · · · ·	liquid eggs, dated 5/6/1 instructions to discard re 8 days old.					
	6. Roast beef, dated remained in the refrigor	5/9/14, and 5 days old, erator.	,				
	7. Cream of mushroo days old, remained in	om soup, dated 5/8/14, the refrigerator.	6				
	The Kelvinator, Freez	er contained:					
	Chicken pieces, da contained excessive f	ated 4/10, in a plastic b frost with the chicken.	ag,				
	and walls exhibited a	urfaces, including shelv heavy frost build-up an areas along the shelvin	ıd				

Printed: 06/03/2014 FORM APPROVED OMB NO. 0938-0391

	(X3) DATE SURVEY COMPLETED	
175169 B. WING	06/03/2014	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
COFFEYVILLE REGIONAL MEDICAL CENTER SNF 1400 W 4TH PO BOX 850 COFFEYVILLE, KS 67337		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371 Continued From page 89 the unit. The back dry store room's farthest exit door, held a sign instructing to keep the door closed. However, this evidenced an opened cover into a crawl space with a rubber hose, which ran from the crawl space with a rubber hose, which ran from the crawl space with a rubber hose, which ran from the ranking lot, allowing an entrance for any type of pest/rodent/vanimal entrance into the dry food store area. The area was unattended by staff during the observation of the dry storage area. Additional concerns in the dry goods area revealed shelving throughout the area, wood as well as metal, in poor condition. The metal shelving exhibited rust and missing finish to the metal shelving and the wood shelving exhibited bare wood, where paint had peeled and/or chipped, creating a difficult to sanitize surface. Two of two walk-in coolers exhibited metal shelving with chipped paint revealing some rust surfaces, creating a difficult to sanitize surface. Additionally, 11 cartons of thawing liquid eggs, dated 4/10/15 lacked an expiration date, however, the label instructed to keep the Item frozen. The label lacked a dispose of date after thawing. One of the 2 walk-in freezers exhibited food spillage on the floor of the unit, appearing as a round orange slice. One of 2 sheet metal doors, on the walk-in coolers, exhibited loose and hanging gray tape. The edges of the sheet metal gaped open, exposing the inner insulation of the door. Additionally, the sticky residue of the hanging tape remained on the door surface.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		175169		B. WING		06/0:	3/2014
	OVIDER OR SUPPLIER ILLE REGIONAL MED	DICAL CENTER SNF	1400 W	ESS, CITY, STA 4TH PO BO VILLE, KS	OX 850		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371	the kitchen area exhit and dust on the exter debris on the filter ins. An additional storage exhibited peeling/chip shelves. A storage area contain boxes sitting directly of debris on the floor. The tilt skillet exhibite enclosed unit. The Hobart pass-throma bag of browning lett smeared date of 5/?? One (located near the in the kitchen, exhibite edges, including white 1/2 inch to 1 inch diar. The drying section of identified a fan, blowing dishes, with a build-up blades, as well as the During sanitation tour following concerns we 1. Observation of the line, lacked areas of lachipped wood along tranging from 1/4 inch	onditioning unit standing bited a heavy build-up of ior of the unit, with visibilitied the unit. area for pots and pansoped paint to the storage ining file cabinets, exhibition to the floor and excess and rusty areas under the tuce, with an unreadable? The triple sink) of 2 microwed spatters to the outer expots of varying sizes meter. The dishwashing area, and directly onto the clear profession of the clear	of lint ole of lint ole se olited ssive e nced le vaves sfrom an to the area. l, the	F 371			

Printed: 06/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175169		B. WING		06/03	3/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE			
COFFEY	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BC VILLE, KS				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 371	(ranging in color from from 1 inch diameter) 3. The convection ov debris, in some areas throughout the interio and the doors. The word much burnt on debris obscured. Dietary st cleaned the oven this obscured, area, held a heavy deincluding all sides, top for food placement. 5. The heating/air conheavy, fluffy, dark grathe unit located in the serving area. Dietary was cleaned by the mand the kitchen staff I maintenance cleaning however, dietary staff several occasions to without success. Star of cleaning for a while of cleaning	brown to white and size to 1/2 inch). en exhibited burnt on he as much as 3/4 inch he rincluding the sides, be indows of the doors he the view into the unit waff O reported the staff past weekend. I waves, located near the ebris on the interior surfer, base and the glass penditioning unit remained by debris over the vents kitchen preparation and staff O, reported this anaintenance department acked awareness of the glaced a work order, of the unit cleaned, and the unit cleaned, are the unit cleaned, are provided the unit in near the same of the unit in near the same of the unit in near the same of the unit in near the unit cleaned, are provided the unit in near the unit in nea	grill saces, late d with sof and area at, ee on eed wid ches rator. s, for ely.	F 371				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI			A. BUILDING		(X3) DATE SURVEY COMPLETED			
		175169		B. WING		06/03/	2014	
	OVIDER OR SUPPLIER	•		RESS, CITY, STA		1		
COFFEYV	ILLE REGIONAL M	EDICAL CENTER SNF		W 4TH PO BOX 850 EYVILLE, KS 67337				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY F OR LSC IDENTIFYING INFORMA	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 371	the cooked and the disposed of after 3 cheeses and condito their expiration of the manufacturer. lack of knowledge items are kept. A fan blowing direct exhibited a build-up of the fan cage and been wiped off, at a cleaning schedul whatever needed of the fan cape and provided by the fact clean of all spills, of and thorough Tues Monday and Wednewekend cook. The instructed staff dail required. The daily staff to clean the meach shift of spills wiped clean of smuthe outside. The facility failed to	en refrigerated items need days and the items such iments, are disposed of redates, marked on the item. The staff further reported of the length of time frozer that to the clean dishes profession of the outer edge that time.	as elated as, by la a en en elated acked elated acked elated acked elaten elate elat	F 371				
F 441 SS=F	483.65 INFECTION SPREAD, LINENS	N CONTROL, PREVENT		F 441				
	Infection Control P	stablish and maintain an rogram designed to provicomfortable environment development and						

, ,		(X1) PROVIDER/SUPPLIER/O			(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY ETED	
		175169		B. WING		06	/03/2014	
	OVIDER OR SUPPLIER	MEDICAL CENTER SNF	1400 W	REET ADDRESS, CITY, STATE, ZIP CODE 1400 W 4TH PO BOX 850 COFFEYVILLE, KS 67337				
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY F OR LSC IDENTIFYING INFORMA	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 441	(a) Infection Contr The facility must e Program under wh (1) Investigates, or in the facility; (2) Decides what p should be applied (3) Maintains a red actions related to a (b) Preventing Spr (1) When the Infect determines that a prevent the spread isolate the residen (2) The facility mu communicable dis from direct contact direct contact will a (3) The facility mu hands after each of hand washing is in professional practi (c) Linens Personnel must ha transport linens so infection.	sease and infection. Fol Program Establish an Infection Continich it - Ontrols, and prevents infection procedures, such as isolated to an individual resident; accord of incidents and corresinfections. Fread of Infection Program resident needs isolation to do finfection, the facility mat. It is the probability of the process of the procedures of the procedure of the procedure of the procedure of the procedure of the process of the process and the process are process are process and the process are process are process are process and the process are process are process and the process are process and process are proce	ctions ion, and end ective onust a a ons od, if eir which	F 441				
	The facility reported with 17 selected for observation, intervals facility failed to en multi-use glucome	is not met as evidenced led a census of 13 resident or sample review. Based view, and record review, the sure adequate sanitization eter (machine to monitor bithe kit for holding the	s, on ne n of a					

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION	I) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	175169		B. WING	 	06/0	3/2014	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE			
COFFEYVILLE REGIONAL MEDICA	AL CENTER SNF		TH PO BOVILLE, KS				
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FU C IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
glucometer supplies and medications to 1 resident manner. Furthermore, the maintain an ongoing infermonitor, track and trend (skilled nursing facility) to control and prevent infection of the fingers glucometer on top of the test strip in place in the uprovided the resident the staff failed to provide any glucometer, before going to administer their insulin medication cart to the nut the glucometer at that time. On 5/15/14 at 11:05 AM, completed a blood sugar resident #63. Staff L rem the nurses desk area the room and the container or esident's overbed table the glucometer check the the container tucked undentered resident #61's root the same procedure of pidirectly onto the resident removed the glucometer and performed the finger the fingerstick the staff pi	In failed to administer to the section control program infections in the SNF or identify, investigated to exist and in the SNF or identify, investigated to identify in the SNF or identify in the staff placed to identify in the staff placed to identify in the staff K then identify in the identify in the staff K then in the identify in the identification. Staff L complete in the identify in the identification in the identification. Staff L repeated in the identification in the identificati	m, to F e, e, ted eter I the th the ne room the ed n at e aff L, for om ents ted with ed ner ting	F 441				

175169 B. WING 06/03/2014	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			175169		B. WING		06/03	/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	<u> </u>	
COFFEYVILLE REGIONAL MEDICAL CENTER SNF 1400 W 4TH PO BOX 850 COFFEYVILLE, KS 67337	COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETING PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETING PROVIDER'S PLAN OF CORRECTION (X5) COMPL	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY F	ULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETION
F 441 glucometer strip (containing blood from the fingerstick) onto the arm of the resident's chair. After completing the fingerstick, staff L removed the test strip with their gloved hands from the glucometer then stepped across the room to the sharps container to dispose of the used tlems, again placing the glucometer until directly onto the nearby dresser. Staff sanitized his/her hands, and then picked up the unit from the dresser, returned the unit into the container with other supplies, and then carried the container with other supplies, and then carried the container with other supplies, and then carried the container out to the nurses desk, without any sanitization observed. Staff L, at 11:15 AM reported this as the normal routine for monitoring blood sugars. An additional interview with licensed nursing staff K and L, at that time, reported that the unit did not come into direct contact with blood; therefore, the unit did not require sanitizing between multiple resident uses. On 5/20/14 at 2:30 PM, administrative nursing staff G, reported the nursing staff are trained at orientation and then yearly regarding cleaning of the glucometer unit. Staff G further reported the unit required wiping down with a disinfectant wipe between each resident. Interview on 5/22/14 at 6:30 PM, with administrative nursing staff are expected to sanitize the unit between each resident use with a sanitizing wipe and further reported the staff are expected to only take the minimum equipment required into the resident's room. Review of the manufacturer's recommendation for the glucometer, revealed recommendations not for multiple resident use, on cleaning the glucose monitoring machine, dated 1/11/2008, instructed staff to clean the unit	F 441	glucometer strip (confingerstick) onto the a After completing the f the test strip with their glucometer then step sharps container to diagain placing the glucomearby dresser. Staff and then picked up the returned the unit into supplies, and then canurses desk, without Staff L, at 11:15 AM routine for monitoring interview with licenset that time, reported the direct contact with blo not require sanitizing uses. On 5/20/14 at 2:30 Pl staff G, reported the rorientation and then y the glucometer unit. Sunit required wiping disetween each resider. Interview on 5/22/14 administrative nursing are expected to sanitiresident use with a sareported the staff are minimum equipment in room. Review of the manufator the glucometer, renot for multiple reside on cleaning the glucometer glucometer, renot for multiple reside on cleaning the glucometer.	staining blood from the arm of the resident's charm of the resident was a commenter unit directly on a sanitized his/her hand the unit from the dresser the container with othe arried the container out any sanitization observation observation observation of the sanitized that as the none of the sanitized that a container out any sanitization observation of the sanitization	ved e the list, to the list, r to the ed. mal tional tiona	F 441			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
175169			B. WING		06/	06/03/2014	
	OVIDER OR SUPPLIER			RESS, CITY, STA			
COFFEYV	ILLE REGIONAL MED	DICAL CENTER SNF		4TH PO BO VVILLE, KS			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 441	Continued From page 96 with warm, soapy water and allowing it to air dry. The policy further noted, if a disinfectant was used, a 1:10 solution of bleach would be used. Review of the disinfectant wipes, referred to as the disinfectant wipes by staff during interviews, identified, the wipes effective on killing bacteria and viruses and lacked identification of any bleach product in the wipes. The facility failed to ensure a disinfecting program for the use of multi-use glucometer equipment, for the residents of the facility requiring blood glucose monitoring. - On 5/15/14 at 8:50 AM, observation revealed licensed nursing staff K touched the touch pad on the medication cart computer, the scanner, drawers of the medication cart and plastic bags on the medication cart without any hand washing observed and then used an ungloved finger to reach into the pill containers of Zestril and Aspirin for resident #64, to retrieve the pills for administration. Staff K administered the contaminated medication pills to the resident's mouth. The facility failed to ensure non-contaminated medications administered to this resident.		as ed. as ews, eria ogram ent, ed ad on egs eshing eto espirin et's	F 441	DEFICIEN	NCY)	
	consisted of daily ove micro lab, looking for organisms, isolation n catheter reviews.	rview of antibiotics and	and				

175169 B. WING 06/03/2014	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	
OTDEET ADDRESS OFFV STATE 710 CODE		06/03/2014		B. WING	175169	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		•				
COFFEYVILLE REGIONAL MEDICAL CENTER SNF 1400 W 4TH PO BOX 850 COFFEYVILLE, KS 67337	YVILLE REGIONAL MI					COFFEYVILLE REGIONAL
PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (FACH CORRECTIVE ACTION SHOULD BE	(EACH DEFICIE	ON SHOULD BE COMPLETION DATE DATE	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PREFIX	ENCY MUST BE PRECEDED BY FULL	PRÉFIX (EACH DEI
F 441 Continued From page 97 5/2/1/14 at 8.44 AM, the infection control program lacked a specific tracking and trending program for the unit and the staff could not provide additional information on tracking and trending for the SNF unit. Staff G reported the overall review of infection control is completed in conjunction with the entire hospital. The facility policy, titled Patient Safety, undated, included the facility monitored and tracked infections electronically with an annual risk assessment performed, and surveillance conducted hospital-wide. The facility failed to develop and implement an infection control program to review, analyze, manage and prevent the spread of infections to the residents of the unit, as part of an on-going infection control program. F 520 483.75(o)(1) GAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility; and at least 3 other members of the facility saff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the	5/21/14 at 8:44 AM lacked a specific tra for the unit and the additional informatic the SNF unit. Staff of infection control with the entire hosp. The facility policy, to included the facility infections electronic assessment performed conducted hospital. The facility failed to infection control promanage and preventhe residents of the infection control promanage and preventhe residents of				I, the infection control program acking and trending program staff could not provide ion on tracking and trending for a Greported the overall review is completed in conjunction bital. Ititled Patient Safety, undated, a monitored and tracked cally with an annual risk med, and surveillance—wide. In develop and implement an orgam to review, analyze, and the spread of infections to equit, as part of an on-going orgam. IMBERS/MEET INS Intain a quality assessment and the consisting of the director of physician designated by the trace of the action of the consisting of the director of the action of the consisting of the director of the action of the consisting of the director of the action of the consisting of the director of the action of the consisting of the director of the action of the consisting of the director of the consisting of the director of the action of the consisting of the director of the action of the consisting of the director of the consisting of the director of the action of the consisting of the director of the consisting of the director of the action of the consisting of the director of the consisting of the co	5/21/14 at 8:44 lacked a specific for the unit and additional inform the SNF unit. So of infection confine with the entire has been seemed to be infections electrons

NAME OF PROVIDER OR SUPPLIER COFFEYVILLE REGIONAL MEDICAL CENTER SNF (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG FREGIX TAG COSSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG FOR THE PROVIDER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG FOR THE PROVIDER SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) FOR THE PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 520 Continued From page 98 compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This Requirement is not met as evidenced by: The facility reported a census of 13 residents. Based on interview and record review, the facility failed to maintain a quality assurance committee that developed and implemented appropriate plans of action to identify quality of care concerns for the residents of the facility. Findings included: - The facility failed to have an effective quality assurance committee to meet the physical, mental, and psychosocial needs of the 13 residents as evidenced by: 1.) Refer to F- 221, the facility failed to ensure 1	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMB			` '	LE CONSTRUCTION	(X3) DATE SUR COMPLETE			
COFFEYVILLE REGIONAL MEDICAL CENTER SNF (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREFIX TAG COntinued From page 98 compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This Requirement is not met as evidenced by: The facility reported a census of 13 residents. Based on interview and record review, the facility failed to maintain a quality assurance committee that developed and implemented appropriate plans of action to identify quality of care concerns for the residents of the facility. Findings included: - The facility failed to have an effective quality assurance committee to meet the physical, mental, and psychosocial needs of the 13 residents as evidenced by: 1.) Refer to F- 221, the facility failed to ensure 1	175169				B. WING 06/			/2014	
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resident (#63) of 3 reviewed for physical restraints, remained free of physical restraints imposed for staff convenience and not required to treat the resident for medical symptoms. 2.) Refer to F- 225, the facility failed to thoroughly investigate and report to the state agency, as required for 1 resident (# 62) of 1 reviewed for accidents who experienced a hip fracture of unknown origin. 3.) Refer to F- 241, the facility failed to maintain personal dignity for 1 (#65) of the 17 sampled residents, during meals and ambulation. Additionally, the facility failed to enhance each	F 520	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 98 compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This Requirement is not met as evidenced by: The facility reported a census of 13 residents. Based on interview and record review, the facility failed to maintain a quality assurance committee that developed and implemented appropriate plans of action to identify quality of care concerns for the residents of the facility. Findings included: - The facility failed to have an effective quality assurance committee to meet the physical, mental, and psychosocial needs of the 13 residents as evidenced by: 1.) Refer to F- 221, the facility failed to ensure 1 resident (#63) of 3 reviewed for physical restraints imposed for staff convenience and not required to treat the resident for medical symptoms. 2.) Refer to F- 225, the facility failed to thoroughly investigate and report to the state agency, as required for 1 resident (#62) of 1 reviewed for accidents who experienced a hip fracture of unknown origin. 3.) Refer to F- 241, the facility failed to maintain personal dignity for 1 (#65) of the 17 sampled		sed by: s. acility ittee ecerns ity ts red to	F 520				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
	175169			B. WING		06/0	06/03/2014	
NAME OF PE	ROVIDER OR SUPPLIER	•	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
COFFEY	/ILLE REGIONAL M	EDICAL CENTER SNF		4TH PO BO YVILLE, KS				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 520	provide iced tea in observation on 5/1 would expect 4.) Refer to F- 248 an ongoing prograt of the SNF (skilled (#68, #9, and #63) activities. 5.) Refer to F- 309 resident (# 34) of the appropriate, physical of the same o	glasses, during dining 4/14, as a reasonable per 4/14, as a reasonable per 3, the facility failed to prove more activities for the residents reviewed of the 3 residents reviewed the 17 reviewed, received cian ordered fluid restrictions, the facility failed to prove sistance, for the 3 residents of (# 59 and #66) for nail circles.	ide dents g 3 ed for ure 1 ons. ide ats for ts to free com ht or ure ation, tatus. sure eter the	F 520				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	175169			B. WING		06/03/2014		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE			
COFFEYVILLE REGIONAL MEDICAL CENTER SNF 1400 W 4TH PO BOX 850 COFFEYVILLE, KS 67337								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETION DATE		
F 520	to administer medical sanitary manner. Futo maintain an ongo to monitor, track and (skilled nursing facilic control and prevent. On 5/22/14 at 4:23 Furshing staff U during reported issues for fur through the department by staff, or any thing director would direct appropriate department. The facility failed to assurance committee appropriate plans of	ations to 1 resident (#64 curthermore, the facility faing infection control proof trend infections in the Stity) to identify, investigat infections within the SNIPM, administrative licensing interview related to Quinther review come upnents, or any incident region-line reported. The Stithat concern to the	ailed gram, SNF e, F. sed A, corted QA ality nent ed	F 520				